

Hospital Acquired Conditions Policy, Facility

IMPORTANT NOTE ABOUT THIS REIMBURSEMENT POLICY

This policy is applicable to UnitedHealthcare Medicare Advantage Plans offered by UnitedHealthcare and its affiliates.

You are responsible for submission of accurate claims. This reimbursement policy is intended to ensure that you are reimbursed based on the code or codes that correctly describe the health care services provided. UnitedHealthcare Medicare Advantage reimbursement policies use Current Procedural Terminology (CPT®*), Centers for Medicare and Medicaid Services (CMS), or other coding guidelines. References to CPT or other sources are for definitional purposes only and do not imply any right to reimbursement.

This reimbursement policy applies to all health care services billed on UB04 forms (CMS 1450) and, when specified, to those billed on CMS 1500 forms. Coding methodology, industry-standard reimbursement logic, regulatory requirements, benefits design and other factors are considered in developing reimbursement policy.

This information is intended to serve only as a general resource regarding UnitedHealthcare's Medicare Advantage reimbursement policy for the services described and is not intended to address every aspect of a reimbursement situation. Accordingly, UnitedHealthcare Medicare Advantage may use reasonable discretion in interpreting and applying this policy to health care services provided in a particular case. Further, the policy does not address all issues related to reimbursement for health care services provided to UnitedHealthcare Medicare Advantage enrollees. Other factors affecting reimbursement may supplement, modify or, in some cases, supersede this policy. These factors may include, but are not limited to: legislative mandates, the facility or other provider contracts, the enrollee's benefit coverage documents**, and/or other reimbursement, medical or drug policies. Finally, this policy may not be implemented exactly the same way on the different electronic claims processing systems used by UnitedHealthcare Medicare Advantage due to programming or other constraints; however, UnitedHealthcare Medicare Advantage strives to minimize these variations.

UnitedHealthcare Medicare Advantage may modify this reimbursement policy at any time to comply with changes in CMS policy and other national standard coding guidelines by publishing a new version of the reimbursement policy on this website. However, the information presented in this reimbursement policy is accurate and current as of the date of publication. UnitedHealthcare Medicare Advantage encourages physicians and other health care professionals to keep current with any CMS policy changes and/or billing requirements by referring to the CMS or your local carrier website regularly. Facilities can sign up for regular distributions for policy or regulatory changes directly from CMS and/or your local carrier. UnitedHealthcare's Medicare Advantage reimbursement policies do not include notations regarding prior authorization requirements.

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*** For more information on a specific enrollee's benefit coverage, please call the customer service number on the back of the member ID card.*

Application

This reimbursement policy applies to UnitedHealthcare Medicare Advantage products.

This reimbursement policy applies to all services reported using the UB-04 form or its electronic equivalent or its successor form. This policy applies to all products and all network and non-network facilities including, but not limited to, non-network authorized and percent of charge contract facilities.

Policy

Overview

Hospital Acquired Conditions (HAC) are serious conditions that patients get during an inpatient hospital stay. If hospitals follow proper procedures, patients are less likely to get these conditions. UnitedHealthcare Medicare Advantage doesn't pay for any of these conditions, and patients can't be billed for them, if acquired while in the hospital. UnitedHealthcare

Medicare Advantage will only pay for these conditions if they were present on admission to the hospital.

Through collaboration with the Centers for Disease Control and Prevention (CDC) and extensive public input, Centers for Medicare and Medicaid Services (CMS) identified HACs (See below) as being reasonably preventable based on the application of published, evidence-based guidelines and thus targeted these HACs for program payment reductions. Selected HACs have to be conditions that are high volume and/or high cost, be identified in the CMS grouper as a complication or comorbidity (CC) or major complication or comorbidity (MCC) for purposes of Medicare Severity Diagnosis Related Grouper (MS-DRG) assignment, and be reasonably preventable using evidence-based guidelines.

On July 31, 2008, in the Inpatient Prospective Payment System (IPPS) Fiscal Year (FY) 2009 Final Rule, CMS included 10 categories of conditions that were selected for the HAC payment provision. Payment implications began October 1, 2008, for these HACs.

These 14 categories of HACs listed below include the new HACs from the IPPS FY 2013 Final Rule which are Surgical Site Infection Following Cardiac Implantable Electronic Device (CIED) and Iatrogenic Pneumothorax with Venous Catheterization. For FY 2014 and FY 2015, there are no additional HACs added.

Effective October 1, 2015, the International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) Version 33 Hospital Acquired Condition (HAC) list replaced the ICD-9-CM Version 32 HAC list.

HAC Categories:

- 01- Foreign Object Retained Following Surgery
- 02- Air Embolism
- 03- Blood Incompatibility
- 04- Stage III and IV Pressure Ulcers
- 05- Falls and Trauma
- 06- Catheter-Associated Urinary Tract Infection (UTI)
- 07- Vascular Catheter-Associated Infection
- 08- Surgical Site Infection (SSI) –Mediastinitis Following Coronary Artery Bypass Graft (CABG)
- 09- Manifestations of Poor Glycemic Control
- 10- Deep Vein Thrombosis (DVT)/Pulmonary Embolism (PE) With Total Knee or Hip Replacement
- 11- Surgical Site Infection (SSI) Following Bariatric Surgery for Obesity
- 12- Surgical Site Infection (SSI) Following Certain Orthopedic Procedures of Spine, Neck, Shoulder or Elbow
- 13- Surgical Site Infection (SSI) Following Cardiac Implantable Electronic Device (CIED) Procedures
- 14- Iatrogenic Pneumothorax w/ Venous Catheterization

Present on Admission Guidelines

To group diagnoses into the proper Diagnosis-related group (DRG), CMS needs to capture a Present on Admission (POA) Indicator for all claims involving inpatient admissions to general acute care hospitals. Collection of POA indicator data is necessary to identify which conditions were acquired during hospitalization for the HAC payment provision as well as for broader public health uses of Medicare data. Use the UB-04 Data Specifications Manual and the ICD-10-CM Official Guidelines for Coding and Reporting to facilitate the assignment of the POA indicator for each "principal" diagnosis and "other" diagnoses codes reported on claim forms UB-04 and 837 Institutional.

The POA Indicator guidelines are not intended to provide guidance on when a condition should be coded, rather to provide guidance on how to apply the POA Indicator to the final set of diagnosis codes that have been assigned in accordance with Sections I, II, and III of the official coding guidelines. Subsequent to the assignment of the ICD-10-CM codes, the POA Indicator should be assigned to all diagnoses that have been coded.

A joint effort between the health care provider and the coder is essential to achieve accurate and complete documentation, code assignment, and reporting of diagnoses and procedures. The importance of consistent, complete documentation in the medical record cannot be overemphasized. Medical record documentation from any qualified health care practitioner who is legally accountable for establishing the patient's diagnosis.

The provider, a provider's billing office, third party billing agents and anyone else involved in the transmission of this data shall insure that any re-sequencing of diagnosis codes prior to transmission to CMS also includes a re-sequencing of the POA Indicators.

General POA Reporting Requirements

- POA indicator reporting is mandatory for all claims involving inpatient admissions to general acute care hospitals or other facilities.
- POA 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 POA.
- A POA Indicator must be assigned to principal and secondary diagnoses (as defined in Section II of the Official Guidelines for Coding and Reporting) and the external cause of injury codes. CMS does not require a POA Indicator for an external cause of injury code unless it is being reported as an "other diagnosis."
- Issues related to inconsistent, missing, conflicting, or unclear documentation must be resolved by the provider.
- If a condition would not be coded and reported based on Uniform Hospital Discharge Data Set definitions and current official coding guidelines, then the POA Indicator would not be reported.

Table 2 below includes a list of the POA indicator reporting options, descriptions, and Medicare payment based on the *Inpatient Prospective Payment System (IPPS) Fiscal Year (FY) 2011 Final Rule*, published by CMS in August 2010. The Final Rule made a change to POA indicator reporting. Effective January 1, 2011, hospitals reporting with the 5010 format will no longer report a POA indicator of "1" for POA exempt codes.

POA Documentation

The importance of consistent, complete documentation in the medical record cannot be overemphasized. 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 POA. In the context of the official coding guidelines, the term "provider" means a physician or any qualified health care practitioner who is legally accountable for establishing the patient's diagnosis.

NOTE: Providers, their billing offices, third party billing agents, and anyone else involved in the transmission of this data must ensure that any re-sequencing of ICD-10-CM diagnosis codes prior to their transmission to CMS also includes a re-sequencing of the POA indicators.

Table 2: CMS POA Indicator Reporting Options, Description, and Payment

Indicator	Description	Medicare Payment
Y	Diagnosis was present at time of inpatient admission.	Payment is made for condition when an HAC is present
N	Diagnosis was not present at time of inpatient admission.	No payment is made for condition when an HAC is present
U	Documentation insufficient to determine if condition was present at the time of inpatient admission.	No payment is made for condition when an HAC is present
W	Clinically undetermined. Provider unable to clinically determine whether the condition was present at the time of inpatient admission.	Payment is made for condition when an HAC is present
1	Unreported/Not used. Exempt from POA reporting. This code is the equivalent of a blank on the UB-04, it was determined that blanks were undesirable when submitting this data via the 4010A. NOTE: The number "1" POA Indicator should not be applied to any codes on the HAC list.	Exempt from POA reporting

Paper Claims

On the UB-04, the POA indicator is the eighth digit of Field Locator (FL) 67, Principal Diagnosis, and the eighth digit of each of the Secondary Diagnosis fields, FL 67 A-Q. In other words, report the applicable POA indicator (Y, N, U, or W) for the principal and any secondary diagnoses and include this as the eighth digit; leave this field blank if the diagnosis is exempt from POA reporting.

Electronic Claims

Submit the POA indicator on the 837I in the appropriate Health Care Information Codes segment as directed by the "UB-04 Data Specifications Manual."

Affected Hospitals

The HHAC payment provision and the POA Indicator requirement only apply to IPPS Hospitals. At this time, the following hospitals are **exempt** from the POA indicator requirement:

- Critical Access Hospitals (CAHs)
- Long-Term Care Hospitals (LTCHs)
- Maryland Waiver Hospitals*
- Cancer Hospitals
- Children's Inpatient Facilities
- Religious Non-Medical Health Care Institutions
- Inpatient Psychiatric Hospitals
- Inpatient Rehabilitation Facilities and
- Veterans Administration/Department of Defense Hospitals

*Maryland Waiver Hospitals must report the POA indicator on all claims.

Reimbursement Guidelines

For discharges occurring on or after October 1, 2008, hospitals will not receive additional payment for cases in which one of the selected conditions was not present on admission. That is, the case would be paid as though the secondary diagnosis were not present.

The Present on Admission Indicator Reporting provision applies only to IPPS hospitals.

CMS also required hospitals to report POA information for both primary and secondary diagnoses when submitting claims for discharges on or after October 1, 2007.

POA Exempt Diagnosis Codes

Certain diagnosis codes are exempt for POA reporting. It is important to review this list to ensure inpatient claims are submitted correctly. Accessing the POA Exempt Diagnosis Code list:

Go to www.cms.gov

- Select "Medicare"
- Under the Medicare Fee-for-Service Payment section select "Hospital Acquired Conditions (Present on Admission Indicator)"
- Select "Coding"
- Select "FY 2019 Present On Admission (POA) Exempt List"

Questions and Answers

1	<p>Q: Do the POA and HAC programs apply to outpatient or ambulatory surgery services?</p> <p>A: No, this program is only for inpatient acute care admissions.</p>
2	<p>Q: If the POA indicator is not on the claim, will the claim be returned?</p> <p>A: Beginning with claims with discharges on or after October 1, 2008, if hospitals do not report a valid POA code for each diagnosis on the claim, the claim will be returned to the hospital for correct submission of POA information.</p>

Codes

[HAC List](#)

Resources

www.cms.gov

CMS Transmittal 756, 1019, and 1240

CMS Fact Sheet: ICN 901046

MLN Matters Article MM5499, MM6086, MM7024, MM8546, MM8709, and SE1131

History

6/7/2019	Policy Version Change (previous versions listed under HAC Professional Policy) <ul style="list-style-type: none"> • Policy Update: Preamble verbiage updated to reference facilities • Policy header changed from CMS 1500 to UB-04 • Title section: Title change from 'Professional' to 'Facility' • Application Section: Verbiage updated to reference UB04 & facilities • History Section: HAC professional policy entries prior to 6/7/2017 archived
1/22/2019	Policy Update (new version) <ul style="list-style-type: none"> • Removed question 3 from Q&A section
1/1/2019	Policy Version Change FY 2019 HAC Link and FY 2019 Present On Admission (POA) Exempt List Updated
11/14/2018	Annual Approval Date and Version Change FY 2018 HAC Link Updated
9/7/2018	Policy number changed from 2017F7002B to 2018R9014A Title change to add Professional
11/8/2017	Annual Review Version Change ICD-9 Table was removed FY 2017 HAC Link Update: ICD-10 Link has been added Preamble has been updated
2/29/2012	Policy Created and Approved