

**Provider Preventable Conditions:
 Health Care Acquired Conditions and Present on Admission Policy, Facility**

IMPORTANT NOTE ABOUT THIS REIMBURSEMENT POLICY

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 Community Plan reimbursement policies uses 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 UB-04 forms and, when specified, to those billed on 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 reference resource regarding UnitedHealthcare Community Plan's reimbursement policy for the services described and is not intended to address every aspect of a reimbursement situation. Accordingly, UnitedHealthcare Community Plan 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 Community Plan enrollees.

Other factors affecting reimbursement supplement, modify or, in some cases, supersede this policy. These factors include, but are not limited to: federal &/or state regulatory requirements, the physician 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 Community Plan due to programming or other constraints; however, UnitedHealthcare Community Plan strives to minimize these variations.

UnitedHealthcare Community Plan may modify this reimbursement policy at any time by publishing a new version of the policy on this Website. However, the information presented in this policy is accurate and current as of the date of publication.

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Application

This reimbursement policy applies to UnitedHealthcare Community Plan Medicaid products.

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

Policy

Overview

Consistent with the Affordable Care Act administered through the Centers for Medicare and Medicaid Services (CMS), UnitedHealthcare Community Plan will implement the requirements related to the Provider Preventable Conditions initiative which includes: 1) adjustment of reimbursement for Health Care Acquired Conditions (HCAC), 2) Present On Admission (POA) indicator requirement 3) no reimbursement for Never Events and 4) Other Provider Preventable Conditions (OPPC) as defined by any additional State Regulations that are in place that expand or further define the CMS regulations.

Reimbursement Guidelines

Health Care Acquired Conditions

For discharges occurring on or after 7/1/2012, hospital reimbursement will be adjusted cases when one of the selected conditions is acquired during hospitalization (i.e., was not present on admission). The case is paid as though the secondary diagnosis is not present. CMS has identified the following to be Health Care Acquired Conditions (HCAC) because they:

- (a) Are high cost or high volume or both,
(b) Result a higher payment when present as a secondary diagnosis
- Payment may be adjusted based on the assignment of a case to an MS-DRG of a higher value as a result of the secondary diagnosis
 - For non-DRG reimbursement methodologies, payment may be adjusted if the health plan can reasonably isolate for nonpayment the portion of the payment directly related treatment for, and related to, the provider-preventable conditions,
- AND**

(c) Could reasonably have been prevented through the application of evidence-based guidelines.

UnitedHealthcare Community Plan will consider the following to be Health Care Acquired Conditions (HCAC) if not Present on Admission (POA) based on the list of diagnoses provided in the CMS Regulations:

- Foreign Object Retained After Surgery
- Air Embolism
- Blood Incompatibility
- Stage III and IV Pressure Ulcers
- Falls and Trauma causing:
 - Fractures
 - Dislocations
 - Intracranial Injuries
 - Crushing Injuries
 - Burns
 - Electric Shock
- Manifestations of Poor Glycemic Control causing:
 - Diabetic Ketoacidosis
 - Nonketotic Hyperosmolar Coma
 - Hypoglycemic Coma
 - Secondary Diabetes with Ketoacidosis
 - Secondary Diabetes with Hyperosmolarity
- Catheter-Associated Urinary Tract Infection (UTI)
- Vascular Catheter-Associated Infection
- Surgical Site Infection Following:
 - Coronary Artery Bypass Graft (CABG)—Mediastinitis
 - Cardiac Implantable Electronic Device (CIED)
 - Bariatric Surgery
 - Laparoscopic Gastric Bypass
 - Gastroenterostomy
 - Laparoscopic Gastric Restrictive Surgery
 - Orthopedic Procedures
 - Spine
 - Neck
 - Shoulder
 - Elbow
- Deep Vein Thrombosis (DVT)/Pulmonary Embolism (PE) Following: **
 - Total Knee Replacement
 - Hip Replacement
- Iatrogenic Pneumothorax with Venous Catheterization

****NOTE:** For Medicaid members, obstetric and pediatric patients are excluded from the Deep Vein Thrombosis/Pulmonary Embolism component only.

There will be no reduction in payment if the condition is indicated to be Present on Admission (POA) by utilizing the appropriate POA indicator on the submitted claim.

Other Provider Preventable Conditions

1. Also included in the Medicaid Payment Adjustments for Provider-Preventable Conditions including Health Care Acquired Conditions regulations is the “Never Events” noncoverage component. Consistent with CMS, UnitedHealthcare Community Plan will not reimburse for a surgical or other invasive procedure, or for services related to a particular surgical or other invasive procedure when any of the following are erroneously performed:

- A different procedure altogether
- The correct procedure but on the wrong body part
- The correct procedure by on the wrong patient

2. UnitedHealthcare Community Plan will align with any state-specific initiatives as they are approved by CMS and implemented by the individual states.

Present On Admission (POA)

The POA indicator is required on all inpatient claims submitted on a UB04 form, its electronic equivalent or its successor form. A POA indicator is required on any diagnosis that is not exempt from the requirement per CMS. All facilities are required to use the appropriate POA indicators unless a particular state has requested and received an exception from CMS to exclude certain types of facilities.

Appropriate POA indicators are:

	DESCRIPTION	PAYMENT
Y	Diagnosis was present at time of inpatient admission.	Payment made for condition
N	Diagnosis was not present at time of inpatient admission.	No payment made for condition
U	Documentation insufficient to determine if condition was present at the time of inpatient admission.	No payment made for condition
W	Clinically undetermined. Provider unable to clinically determine whether the condition was present at the time of inpatient admission.	Payment made for condition
1	Exempt from POA reporting. This code is the equivalent of a blank on the UB-04, however, it was determined that blanks were undesirable NOTE: The number “1” is no longer valid on claims submitted under the version 5010 format, effective January 1, 2011. The POA field will instead be left blank for codes exempt from POA reporting.	Exempt from POA reporting

Additional information can be found on the CMS website:

Medicaid: <https://www.medicaid.gov/medicaid/finance/provider-preventable-conditions/index.html>

Medicare: <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/wPOA-Fact-Sheet.pdf>

[CMS FY 2021 ICD-10 HAC List](#)

[CMS FY 2021 ICD-10 POA Exempt List](#)

State Exceptions	
Hawaii	The Facility Types that are exempt from this policy includes all the Facility Types that are listed in the “Affected Hospitals” list provided in the CMS Guideline found in the following CMS.gov link: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalAcqCond/AffectedHospitals The HI State Medicaid follows CMS Guidelines for the Present on Admission (POA) Indicator requirement and Hospital-Acquired Conditions (HAC) requirements.
Indiana	Per the state of Indiana regulations, "The state shall not pay for provider-preventable conditions, as defined at 42 CFR 447.26(b)." (Office of the Secretary of Family and Social Services; 405 IAC 1-11.5-2).
Maryland	Maryland is exempt from this policy
Rhode Island	RI Children’s Hospitals, Cancer Hospitals and Inpatient Psychiatric facilities are exempt from reporting POA

Definitions	
DRG	Diagnosis Related Grouping
HAC	Hospital Acquired Condition
HCAC	Health Care Acquired Condition
OPPC	Other Provider Preventable Condition
POA	Present on Admission: 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.
PPC	Provider Preventable Condition

Questions and Answers	
1	<p>Q: Are facilities that are currently exempt from the Medicare HAC initiative also exempt from the Medicaid Health Care Acquired Conditions initiative?</p> <p>A: No, per CMS the final rule has language indicating it is applicable to ALL inpatient hospital settings. Thus, UnitedHealthcare Community Plan will apply this policy to all inpatient hospital settings for Medicaid members in order to be compliant with the CMS Mandate.</p>
2	<p>Q: What if my state has initiatives that are different than the CMS program?</p> <p>A: CMS is encouraging states to develop additional initiatives. However, states must comply with the minimum level of the CMS mandate which includes the HCAC diagnoses and requirements related to adjustment in payment and nonpayment of the 3 NCDs</p>
3	<p>Q: Is this initiative limited to the current diagnoses?</p> <p>A: CMS reserves the right to revise both the HCAC list and the NCD list at any time. UnitedHealthcare Community Plan will follow both the CMS mandate and any additional regulations implemented by individual states that have been approved by CMS for this initiative.</p>
4	<p>Q: Is POA indicator required?</p>

A: UnitedHealthcare Community Plan will identify HCAC claims based on the appropriate use of the POA indicator. Claims that do not have the POA indicator included may be subject to denials and required to re-submit. POA indicator is not required on SNF (Skilled Nursing Facility) claims.

Resources

Individual state Medicaid regulations, manuals & fee schedules

American Medical Association, *Current Procedural Terminology (CPT®) Professional Edition* and associated publications and services

Centers for Medicare and Medicaid Services, CMS Manual System and other CMS publications and services
 Centers for Medicare and Medicaid Services, Healthcare Common Procedure Coding System, HCPCS Release and Code Sets

National Uniform Billing Committee (NUBC)

CODE OF FEDERAL REGULATIONS www.ecfr.gov

- TITLE 42-PUBLIC HEALTH
- CHAPTER IV—CENTERS FOR MEDICARE & MEDICAID SERVICES, DEPARTMENT OF HEALTH AND HUMAN SERVICES
- SUBCHAPTER C—MEDICAL ASSISTANCE PROGRAMS

§434.6 General requirements for all contracts and subcontracts.

(a) *Contracts.* All contracts under this part must include all of the following:

(12) Specify the following:

- (i) No payment will be made by the contractor to a provider for provider-preventable conditions, as identified in the State plan.

§438.6 Contract requirements

(f) *Compliance with contracting rules.* All contracts must meet the following provisions

(2) Provide for the following:

- (i) Compliance with the requirements mandating provider identification of provider-preventable conditions as a condition of payment, as well as the prohibition against payment for provider-preventable conditions as set forth in §434.6(a)(12) and §447.26 of this subchapter.
- (ii) Reporting all identified provider-preventable conditions in a form or frequency as may be specified by the State.

§447.26 Prohibition on payment for provider-preventable conditions

(a) *Basis and purpose.* The purpose of this section is to protect Medicaid beneficiaries and the Medicaid program by prohibiting payments by States for services related to provider-preventable conditions.

- (1) Section 2702 of the Affordable Care Act requires that the Secretary exercise authority to prohibit Federal payment for certain provider preventable conditions (PPCs) and health care-acquired conditions (HCACs).

History

9/3/2021	Policy Version Change Policy Section: State Exceptions Section: Indiana added History Section: Entries prior to 9/3/2021
5/23/2021	Policy Version Change

	Policy Section: Updated the CMS FY ICD-10 HAC and CMS FY ICD-10 POA Exempt Lists State Exceptions Section: Hawaii added
11/16/2020	Policy Section: Updated the CMS FY ICD-10 HAC and CMS FY ICD-10 POA Exempt Lists
3/6/2020	Annual Anniversary Date and Version Change History section: Entries prior to 1/1/2018 archived
10/1/2019	Policy Section: Updated the CMS FY ICD-10 HAC and CMS FY ICD-10 POA Exempt Lists
12/1/2011	Policy Implemented by UnitedHealthcare Community & State for Tennessee only