Hospital Acquired Conditions Policy

<table>
<thead>
<tr>
<th>Policy Number</th>
<th>2016F7002B</th>
<th>Annual Approval Date</th>
<th>07/13/2016</th>
<th>Approved By</th>
<th>Payment Policy Oversight Committee</th>
</tr>
</thead>
</table>

**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 CMS 1500 forms and, when specified, to those billed on UB04 forms (CMS 1450). 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 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 physician or other provider contracts, and/or the enrollee's benefit coverage documents**. 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 healthcare professionals to keep current with any CMS policy changes and/or billing requirements by referring to the CMS or your local carrier website regularly. Physicians and other healthcare professionals 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. Services requiring prior authorization can be found at UnitedHealthcareOnline.com > Notifications/Prior Authorizations.

*CPT® is a registered trademark of the American Medical Association.

** For more information on a specific enrollee’s benefit coverage, please call the customer service number on the back of the member ID card or refer to the Administrative Guide.
Application

This reimbursement policy applies to services reported using the 1500 Health Insurance Claim Form (a/k/a CMS-1500) or its electronic equivalent or its successor form. This policy applies to all products and all network and non-network physicians and other qualified health care professionals, including, but not limited to, non-network authorized and percent of charge contract physicians and other qualified health care professionals.

Payment Policies for Employer & Individual and for Community and State please use this link. Employer & Individual are listed under Reimbursement Policies-Commercial. Community and State are listed under UnitedHealthcare Community Plan Reimbursement Policies.

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. UHC doesn't pay for any of these conditions, and patients can't be billed for them, if acquired while in the hospital. UHC 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, CMS identified HACs (See Table 1 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.

In August 2012, CMS published the Inpatient Prospective Payment System (IPPS) Fiscal Year (FY) 2013 Final Rule. The Final Rule discusses the addition of two new HACs, one of which is a new Surgical Site Infection Following Cardiac Implantable Electronic Device (CIED) and the other is Iatrogenic Pneumothorax with Venous Catheterization.

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: (See Table 1):

1. Foreign Object Retained After Surgery
2. Air Embolism
3. Blood Incompatibility
4. Stage III and IV Pressure Ulcers
5. Falls and Trauma
6. Manifestations of Poor Glycemic Control
7. Catheter-Associated Infection (UTI)
8. Vascular Catheter-Associated Infection
9. Surgical Site Infection, Mediastinitis, Following Coronary Artery Bypass Graft (CABG):
10. Surgical Site Infection Following Bariatric Surgery for Obesity
11. Surgical Site Infection Following Certain Orthopedic Procedures
12. Surgical Site Infection Following Cardiac Implantable Electronic Device (CIED)
13. Deep Vein Thrombosis (DVT) Pulmonary Embolism (PE) Following Certain Orthopedic Procedures
14. Iatrogenic Pneumothorax with Venous Catheterization
<table>
<thead>
<tr>
<th>HAC</th>
<th>CC/MCC (ICD-9-CM Codes)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Foreign Object Retained After Surgery</td>
<td>998.4 (CC) 998.7 (CC)</td>
</tr>
<tr>
<td>Air Embolism</td>
<td>999.1 (MCC)</td>
</tr>
<tr>
<td>Blood Incompatibility</td>
<td>999.60 (CC) 999.61 (CC) 999.62 (CC) 999.63 (CC) 999.69 (CC)</td>
</tr>
<tr>
<td>Pressure Ulcer Stages III &amp; IV</td>
<td>707.23 (MCC) 707.24 (MCC)</td>
</tr>
<tr>
<td>Falls and Trauma</td>
<td>Codes within these ranges on the CC/MCC list:</td>
</tr>
<tr>
<td>• Fracture</td>
<td>800-829</td>
</tr>
<tr>
<td>• Dislocation</td>
<td>830-839</td>
</tr>
<tr>
<td>• Intracranial Injury</td>
<td>850-854</td>
</tr>
<tr>
<td>• Crushing Injury</td>
<td>925-929</td>
</tr>
<tr>
<td>• Burn</td>
<td>940-949</td>
</tr>
<tr>
<td>• Other injuries</td>
<td>991-994</td>
</tr>
<tr>
<td>Catheter-Associated Urinary Tract Infection (UTI)</td>
<td>996.64 (CC) Also excludes the following from acting as a CC/MCC:</td>
</tr>
<tr>
<td></td>
<td>112.2 (CC) 590.10 (CC) 590.11 (MCC) 590.2 (MCC) 590.3 (CC) 590.80 (CC) 590.81 (CC) 595.0 (CC) 597.0 (CC) 599.0 (CC)</td>
</tr>
<tr>
<td>Vascular Catheter-Associated Infection</td>
<td>999.31 (CC) 999.32 (CC) 999.33 (CC)</td>
</tr>
<tr>
<td>Manifestations of Poor Glycemic Control</td>
<td>250.10-250.13 (MCC) 250.20-250.23 (MCC) 251.0 (CC) 249.10-249.11 (MCC) 249.20-249.21 (MCC)</td>
</tr>
<tr>
<td>• Diabetic Ketoacidosis</td>
<td></td>
</tr>
<tr>
<td>• Nonketotic Hyperosmolar Coma</td>
<td></td>
</tr>
<tr>
<td>• Hypoglycemic Coma</td>
<td></td>
</tr>
<tr>
<td>• Secondary Diabetes with Ketoacidosis</td>
<td></td>
</tr>
<tr>
<td>• Secondary Diabetes with Hyperomolarity</td>
<td></td>
</tr>
<tr>
<td>Surgical Site Infection, Mediastinitis, following Coronary Artery Bypass Graft (CABG)</td>
<td>519.2 (MCC) And one of the following procedure codes:</td>
</tr>
<tr>
<td></td>
<td>36.10-36.19</td>
</tr>
<tr>
<td>Surgical Site Infection Following Certain Orthopedic Procedures:</td>
<td>996.67 (CC) 998.59 (CC)</td>
</tr>
</tbody>
</table>
• Spine
• Neck
• Shoulder
• Elbow
And on of the following procedure codes: 81.01-81.08, 81.23-81.24, 81.31-81.38, 81.83, or 81.85

Surgical Site Infection Following Bariatric Surgery for Obesity:
• Laparoscopic Gastric Bypass
• Gastroenterostomy
• Laparoscopic Gastric Restrictive Surgery
Principal Diagnosis: 278.01
539.01 (CC)
539.81 (CC)
998.59 (CC)
And one of the following procedure codes: 44.38, 44.39, or 44.95

Surgical Site Infection Following Cardiac Implantable Electronic Device (CIED)
996.61 (CC)
998.59 (CC)
And one of the following procedure codes: 00.50, 00.51, 00.52, 00.53, 00.54, 37.80, 37.81, 37.82, 37.83, 37.85, 37.86, 37.87, 37.94, 37.96, 37.98, 37.74, 37.75, 37.76, 37.77, 37.79, 37.89

Deep Vein Thrombosis and Pulmonary Embolism Following Certain Orthopedic Procedures:
• Total Knee Replacement
• Hip Replacement
415.11 (MCC)
415.13 (MCC)
415.19 (MCC)
453.40-453.42 (CC)
And one of the following procedure codes: 00.85-00.87, 81.51-81.52, or 81.54

Iatrogenic Pneumothorax with Venous Catheterization
512.1 (CC)
And the following procedure code: 38.93

Present on Admission Guidelines
To group diagnoses into the proper 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-9-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-9-CM codes, the POA Indicator should be assigned to all diagnoses that have been coded.

A joint effort between the healthcare 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 healthcare 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 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 present on admission. 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-9-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

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Description</th>
<th>Medicare Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Y</td>
<td>Diagnosis was present at time of inpatient admission.</td>
<td>Payment is made for condition when an HAC is present</td>
</tr>
<tr>
<td>N</td>
<td>Diagnosis was not present at time of inpatient admission.</td>
<td>No payment is made for condition when an HAC is present</td>
</tr>
<tr>
<td>U</td>
<td>Documentation insufficient to determine if condition was present at the time of inpatient admission.</td>
<td>No payment is made for condition when an HAC is present</td>
</tr>
<tr>
<td>W</td>
<td>Clinically undetermined. Provider unable to clinically determine whether the condition was present at the time of inpatient admission.</td>
<td>Payment is made for condition when an HAC is present</td>
</tr>
<tr>
<td>1</td>
<td>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. <strong>NOTE:</strong> The number “1” POA Indicator should not be applied to any codes on the HAC list.</td>
<td>Exempt from POA reporting</td>
</tr>
</tbody>
</table>

**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**
UnitedHealthcare® Medicare Advantage
Reimbursement Policy
CMS 1500

The Hospital-Acquired Conditions (HAC) payment provision and the Present on Admission (POA) Indicator requirement only apply to Inpatient Prospective Payment Systems (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 present on admission 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. In August 2012, CMS published the Inpatient Prospective Payment System (IPPS) Fiscal Year (FY) 2013 Final Rule which included two additional ICD-9-CM codes for the Vascular Catheter-Associated Infection HAC Category.

Accessing the POA Exempt Diagnosis Code list:
- Go to [http://www.cms.gov](http://www.cms.gov)
- Select "Medicare"
- Select "Hospital Acquired Conditions (Present on Admission Indicator)"
- Select "ICD-10-CM/PCS HACs List"
- Under Related Links select "ICD-10 MS-DRG Conversion Project"
- Select "2015 Present On Admission (POA) Exempt List" under Downloads section

### ICD-10-CM/PCS HACs List

ICD-10-CM/PCS Hospital Acquired Conditions [HAC] Translation List using V32 of the MS-DRG Definitions Manual has been posted for public review and is located in 'Appendix I' of the 'ICD-10-CM/PCS MS-DRG V32 Definitions Manual Table of Contents - Full Titles – Text Version under the Downloads section on the CMS website. Implementation on October 1, 2015, can be accessed at:
- Go to [http://www.cms.gov](http://www.cms.gov)
- Select "Medicare"
- Select "Hospital Acquired Conditions (Present on Admission Indicator)"
- Select "ICD-10-CM/PCS HACs List"
- Under Related Links select "ICD-10 MS-DRG Conversion Project"
Definitions

<table>
<thead>
<tr>
<th>CC</th>
<th>Corresponding complication or co-morbidity</th>
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<tbody>
<tr>
<td>DRG</td>
<td>Diagnosis Related Grouper</td>
</tr>
<tr>
<td>HAC</td>
<td>Hospital Acquired Condition</td>
</tr>
<tr>
<td>IPPS</td>
<td>Inpatient Prospective Payment System</td>
</tr>
<tr>
<td>MCC</td>
<td>Major complication or co-morbidity</td>
</tr>
<tr>
<td>POA</td>
<td>Present on Admission</td>
</tr>
</tbody>
</table>

Questions and Answers

1. Q: Do the POA and Hospital-Acquired Conditions (HAC) programs apply to outpatient or ambulatory surgery services?  
   A: No, this program is only for inpatient acute care admissions.

2. Q: If the POA indicator is not on the claim, will the claim be returned?  
   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.

Codes

CPT code section

See Table 1: HACs and ICD-9-CM Codes

Resources

CMS Transmittals

- Transmittal 756, Change Request 7024, Dated 08/13/2010 (5010 Implementation—Changes to Present on Admission (POA) Indicator “1” and the K3 Segment)
- Transmittal 1019, Change Request 1019, Dated 01/25/2012 (Update to the Fiscal Year (FY) 2012 List of Codes Exempt from Reporting Present on Admission (POA))
- Transmittal 1240, Change Request 5499, Dated 05/11/2007 (Present on Admission Indicator)

MLN Matters

- Article MM5499, Present on Admission (POA) Indicator
- Article MM6086 Revised, Hospitals Exempt from Present on Admission (POA) Reporting (i.e. non-Inpatient Prospective Payment System (IPPS) Hospitals) and the Grouper
- Article MM7024 Revised, Version 5010 Implementation—Changes to Present on Admission (POA) Indicator “1” and the K3 Segment
- Article MM8546 Revised, Addition of New Fields and Expansion of Existing Model 1 Discount Percentage Field in the Inpatient Hospital Provider Specific File (PSF) and Renaming Payment Fields in the Inpatient Prospective Payment System (IPPS) Pricer Output
- Article MM8709, Present on Admission (POA) Indicator Editing for Maryland Waiver Hospitals
- Article SE1131 Revised, Revised Important Update Regarding 5010/D.0 Implementation – Action Needed Now

Others

Fiscal Year 2015 Policy and Payment Changes for Inpatient Stays in Acute-Care Hospitals and Long-Term Care Hospitals, CMS Website
Hospital-Acquired Conditions (HAC) in Acute Inpatient Prospective Payment System (IPPS) Hospitals Fact Sheet, ICN 901046, CMS Website
Hospital-Acquired Conditions (Present on Admission Indicator), CMS website
Hospital-Acquired Conditions, Present on Admission (POA), Coding, CMS website
Present on Admission (POA) Indicator Reporting by Acute Inpatient Prospective Payment System (IPPS) Hospitals Fact Sheet; ICN 901046 October 2011 (ICN901046)
RTI Project Final Report, Evidence-based Guidelines for Selected and Previously Considered Hospital-Acquired Conditions, CMS Website
RTI Project Final Report, Readmissions Due to Hospital-Acquired Conditions (HACs): Multivariate Modeling and Under-coding Analyses, CMS Website

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<tr>
<th>History</th>
<th>Date</th>
<th>Details</th>
</tr>
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</table>
|                  | 07/13/2016 | Annual Review  
Updated HAC’S categories from 11 categories to 14 |
|                  | 05/01/2016 | Reorganized and reformatted policy  
  o Transferred content to new template (no change to content)  
  o Reassigned policy number |
|                  | 08/12/2015 | Annual review  |

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