Health Care-Acquired Conditions

Reimbursement Policy ID: RPC.0044.01CH

Recent review date: 06/2025

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Keystone First – CHIP (Children's Health Insurance Program) reimbursement policies and their resulting edits are based on guidelines from established industry sources, such as the Centers for Medicare and Medicaid Services (CMS), the American Medical Association (AMA), state and federal regulatory agencies, and medical specialty professional societies. Reimbursement policies are intended as a general reference and do not constitute a contract or other guarantee of payment. Keystone First – CHIP may use reasonable discretion in interpreting and applying its policies to services provided in a particular case and may modify its policies at any time.

In making claim payment determinations, the health plan also uses coding terminology and methodologies based on accepted industry standards, including Current Procedural Terminology (CPT); the Healthcare Common Procedure Coding System (HCPCS); and the International Classification of Diseases,10th Revision, Clinical Modification (ICD-10-CM), and other relevant sources. Other factors that may affect payment include medical record documentation, legislative or regulatory mandates, a provider's contract, a member's eligibility in receiving covered services, submission of clean claims, and other health plan policies, and other relevant factors. These factors may supplement, modify, or in some cases supersede reimbursement policies.

This reimbursement policy applies to all health care services billed on a CMS-1500 form or its electronic equivalent, or when billed on a UB-04 form or its electronic equivalent.

To the extent that any procedure and/or diagnosis codes are specified in this policy, such inclusion is provided for reference purposes only, may not be all inclusive, and is not intended to serve as billing instructions. Listing of a code in this policy does not imply that the service described by the code is a covered or non-covered health service. Benefit coverage for health services is determined by federal, state, or contractual requirements and applicable laws that may require coverage for a specific service. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. Other Policies and Guidelines may apply.

Policy Overview

This policy addresses payment reductions for Hospital-Acquired Conditions (HAC), Health Care-Acquired Condition(s) (HCAC), Never Events, and Provider Preventable Conditions. The Hospital-Acquired Conditions Present on Admission (HAC-POA) program arose from the Deficit Reduction Act of 2005, and generally defined a number of conditions for which Medicare would no longer pay a higher diagnosis-related group (DRG) rate if the conditions occurred in the inpatient setting and were not present on admission. Section 2702 of the Patient Protection and Affordable Care Act, Sections 1886(d)(4)(D)(iv) and 1886(p)(3) of the Social Security Act, and Title 42 Code of Federal Regulations (CFR) Part 447, Subpart A had the effect of extending the requirements of the HAC-POA program to state Medicaid programs, where hospital-acquired conditions (HACs) are known as health care-acquired conditions (HCACs). For purposes of this policy, the terms HAC and HCAC are considered to be interchangeable.

The conditions that are considered to be HACs/HCACs, Never Events, or Other Provider-Preventable are included in this payment reduction. The list of conditions is as follows:

- Foreign Object Retained After Surgery
- Air Embolism
- Blood Incompatibility
- Stage III and IV Pressure Ulcers
- Falls and Trauma, including:
    - Fractures
    - Dislocations
    - Intracranial Injuries
    - Crushing Injuries
    - Burn
    - Other Injuries
- Manifestations of Poor Glycemic Control, including:
    - Diabetic Ketoacidosis
    - Nonketotic Hyperosmolar Coma
    - Hypoglycemic Coma
    - Secondary Diabetes with Ketoacidosis
    - Secondary Diabetes with Hyperosmolarity
- Catheter-Associated Urinary Tract Infection (CAUTI)
- Vascular Catheter-Associated Infection
- Surgical Site Infection, Mediastinitis, Following Coronary Artery Bypass Graft (CABG):
- Surgical Site Infection Following Bariatric Surgery for Obesity
    - Laparoscopic Gastric Bypass
    - Gastroenterostomy
    - Laparoscopic Gastric Restrictive Surgery
- Surgical Site Infection Following Certain Orthopedic Procedures
    - Spine
    - Neck
    - Shoulder
    - Elbow
- Surgical Site Infection Following Cardiac Implantable Electronic Device (CIED)
- Deep Vein Thrombosis/Pulmonary Embolism (DVT/PE) following certain orthopedic procedures, excluding pediatric patients (defined as those under the age of 18), and obstetric patients (defined as patients with at least one primary or secondary diagnosis code that includes an indication of pregnancy):
    - Total Knee Replacement
    - Hip Replacement
- Iatrogenic Pneumothorax with Venous Catheterization
- Provider-Preventable Conditions
    - Surgery or Other Invasive Procedure Performed on the Wrong Body Part
    - Surgery or Other Invasive Procedure Performed on the Wrong Patient
    - Wrong Surgery or Other Invasive Procedure Performed on a Patient
- Other Provider-Preventable Conditions identified in a state’s Medicaid plan.

Exceptions

N/A

Reimbursement Guidelines

The HCACs in the list above are identified by ICD-10-CM diagnosis codes as illustrated in the table that follows. Present on admission (POA) indicators are assigned to each diagnosis after the patient is discharged at the time the medical record is coded. They indicate whether the diagnosis was present on admission to acute care. A complete list of ICD-10-CM codes not requiring a POA indicator is found at https://www.cms.gov/medicare/coding-billing/icd-10-codes/2025-icd-10-cm. Present on admission (POA) indicators and subsequent payment status are shown in the table below.

POA Indicators and Payment Status		
ICD-10-CM Code	**Description**	**Payment Status**
Y	Diagnosis was present at time of inpatient admission.	[Plan) will pay the CC/MCC* diagnosis-related group (DRG) rate for those selected HCACs that are coded with "Y" for the POA indicator.
N	Diagnosis was not present at time of inpatient admission.	[Plan] will not pay the CC/MCC DRG rate for those selected HCACs that are coded with "N" for the POA indicator.
U	Documentation insufficient to determine if the condition was present at the time of inpatient admission.	[Plan] will not pay the CC/MCC DRG rate for those selected HCACs that are coded as "U" for the POA indicator.
W	Clinically undetermined. Provider is unable to clinically determine whether the condition was present at the time of inpatient admission.	[Plan] will pay the CC/MCC DRG rate for those selected HCACs that are coded as "W" for the POA indicator.
Blank	Unreported/Not used. A blank on the UB-04 indicates Exempt from POA.	CHIP will not pay the CC/MCC DRG rate for those selected HACs with a blank field for the POA indicator.

* CC = complication or comorbidity; MCC = major complication or comorbidity; DRG= diagnosis-related group.

Diagnosis codes may be defined as either a complication or comorbidity (CC) or a major complication or comorbidity (MCC) when used as a secondary diagnosis. The presence or absence of these diagnosis categories will affect reimbursement. The table below illustrates this.

Example: Cardiac pacemaker revision except device replacement

MCC* on the claim	CC* on the claim	DRG code
Yes	n/a	260 (revision with MCC)
No	Yes	261 (revision with CC)
No	No	262 (revision without CC or MCC)

* CC = complication or comorbidity; MCC = major complication or comorbidity; DRG = diagnosis-related group.

Payment for a claim with an HCAC that was not present on admission will be reduced by removing the HCAC diagnosis from the DRG calculation. This may result in a lower payment. If there is a DRG outlier following

removal of the HCAC diagnosis, the medical record and itemized bill will be reviewed for possible denial of days or covered charges due to the HCAC. A physician reviewer will make the final determination of days/covered charges to remove from the itemized bill that are related to the HCAC.

For non-DRG reimbursement methodologies, payment may be adjusted if the health plan can reasonably isolate the portion of the payment directly related to treatment of the health care-acquired condition or provider-preventable condition.

Definitions

Health Care-Acquired Conditions (HCACs)
HCACs are conditions that occur in an inpatient setting and that are high cost or high volume or both, may result in the assignment of a case to a DRG that has a higher payment when present as a secondary diagnosis, and could reasonably have been prevented through the application of evidence-based guidelines.

Never Event
Never events are serious and costly errors in the provision of health care services that should never happen. Never events which include surgeries performed on the wrong body part or transfusion of mismatched blood—cause serious injury or death to beneficiaries, and result in increased costs to the Medicare/Medicaid programs to treat the consequences of the error.

Provider Preventable Conditions (PPC)
PPCs are conditions that meet the definition of a Health Care-Acquired Condition (HCAC), a Never Event, or an Other Provider-Preventable Condition. Health Care-Acquired Conditions (HCACs), occur in inpatient hospital settings, and Other Provider-Preventable Conditions (OPPCs) may occur in either an inpatient or outpatient health care setting.

Edit Sources

I. Current Procedural Terminology (CPT) and associated publications and services.
II. International Classification of Diseases,10th Revision, Clinical Modification (ICD-10).
III. Healthcare Common Procedure Coding System (HCPCS).
IV. Centers for Medicare and Medicaid Services (CMS).
V. https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalAcqCond/icd10_hacs.
VI. https://www.cms.gov/medicare/payment/fee-for-service-providers/hospital-aquired-conditions-hac/affected-hospitals.
VII. https://www.cms.gov/medicare/coding-billing/icd-10-codes/2025-icd-10-cm.
VIII. The National Correct Coding Initiative (NCCI).
IX. Corresponding Keystone First - CHIP Clinical Policies.
X. Applicable Keystone First - CHIP manual reference.
XI. Commonwealth of Pennsylvania Children’s Health Insurance Program guidance.
XII. Commonwealth of Pennsylvania Medicaid Program fee schedule(s).
XIII. Applicable Keystone First – CHIP manual reference
XIV. Applicable Pennsylvania guidance

Attachments

N/A

Associated Policies

N/A

Policy History

06/2025	Minor updates to formatting and syntax
06/2025	Reimbursement Policy Committee approval
04/2025	Revised preamble
04/2024	Revised preamble
08/2023	Removal of Policy implemented by Keystone First – CHIP from policy history section Caritas
01/2023	Template revised • Preamble revised • Applicable Claim Types table removed • Coding section renamed to Reimbursement Guidelines • Associated Policies section added