Health Care Acquired Condition (HCAC) / Present on Admission (POA)

***all red text is new for 12/05/2014**

The PPACA (Patient Protection and Affordable Care Act) requires that states not pay for provider preventable conditions including health care acquired conditions (HCACs) and other provider-preventable conditions (OPPCs). Providers currently report health care acquired conditions using Present on Admission (POA) indicators on inpatient claims. However, they are only validated for presence and validity. All processing of HCACs in relation to reimbursement is currently completed outside of claims processing.

The implementation of DRGs for inpatient admissions on or after January 1, 2015 will enable Connecticut to change the administration of how claims with a HCAC are reimbursed. While OPPC and health care acquired condition portion of this policy was previously handled through the cost settlement process, going forward, this policy will be administered in claims processing.

For inpatient claims with dates of admission 10/1/2015 and after, hospitals will not receive the higher DRG payment for cases when one of the selected conditions (see table 1 and 2) is acquired during hospitalization (i.e., was not present on admission).

The Connecticut Medical Assistance Program (CMAP) will not pay for services identified as Health Care-Acquired Conditions (HCACs). The predetermined list of diagnosis codes that DSS considers to be a HCAC, if there was no indication that the condition was present on admission, will not be considered when assigning the APR DRG for the claim.

HCAC is identified by POA indicator = N (Diagnosis was not present at time of inpatient admission) or U (Documentation insufficient to determine if condition was present at the time of inpatient admission).

Table 1

The diagnosis code has an associated POA indicator of 'N' or 'U' and the diagnosis is one of the following values:

HCAC	Diagnosis Code (ICD-9)
Foreign Object Retained after Surgery	998.4 998.7
Air Embolism	999.1
Blood Incompatibility	999.60 999.61 999.62 999.69
Pressure Ulcer Stages III & IV	702.23 707.24
Falls and Trauma: • Fracture	Codes within these ranges on the CC/MCC list - Refer to link below:

• Dislocation • Injury • Crushing Injury • Burn • Other Injuries	800-829 830-839 850-854 925-929 940-949 991-994
Catheter-Associated Urinary Tract Infection (UTI)	996.64 except if one of the following diagnosis codes is also present on the claim • 112.2 • 590.10 • 590.11 • 590.2 • 590.3 • 590.80 • 590.81 • 595.0 • 597.0 • 599.0
Vascular Catheter-Associated Infection	999.31 999.32 999.33
Manifestations of Poor Glycemic Control • Diabetic Ketoacidosis • Nonketotic Hyperosmolar Coma • Hypoglycemic Coma • Secondary Diabetes with Ketoacidosis • Secondary Diabetes with Hyperosmolarity	250.10 - 250.13 250.20 – 250.23 251.00 249.10 - 249.11 249.20 - 249.21

Or

Table 2

The diagnosis code has an associated POA indicator of 'N' or 'U' and the diagnosis and one of the listed surgical procedure codes on the claim are as follows:

HCAC	CC/MCC(ICD-9-CM Codes)	Procedure codes
Surgical Site Infection, Mediastinitis, Following Coronary Artery Bypass Graft (CABG)	519.2	36.10 – 36.19
Surgical site infection following certain Orthopedic procedures: • Spine • Neck • Shoulder • Elbow	996.67, 998.59	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 : Primary dx = 278.01 • Laparoscopic Gastric Bypass • Gastroenterostomy • Laparoscopic Gastric Restrictive Surgery	539.01, 539.81, 998.59	44.38, 44.39, 44.95

Surgical site infection following Cardiac Implantable Electronic Device (CIED)	996.61, 998.59	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. Exclude Pediatric (based on age < 21) and exclude obstetrics. Total Knee Replacement Hip Replacement	415.11, 415.13, 415.19, 453.40 – 453.42	00.85 – 00.87, 81.51-81.52 or 81.54
Iatrogenic Pneumothorax with Venous Catheterization	512.1	38.93

HCAC / POA FAQ

1. Are there any billing changes in relation to HCAC and POA for inpatient admission on or after January 1, 2015?

    A. There are no scheduled billing changes in relation to HCAC and POA indicators on hospital claims submissions as of January 1, 2015.

2. Will the DRG implementation impact the processing of Other Provider Preventable Conditions?

    A. No. Wrong surgical or other invasive procedure performed on a wrong body part or on the wrong patient will continue to deny the claim.

Helpful Links:

CC/MCC List - scroll to the bottom and click on table 6 in the downloads section which will then open a zip file (6J) and 6(I): http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/FY-2014-IPPS-Final-Rule-Home-Page-Items/FY-2014-IPPS-Final-Rule-CMS-1599-F-Tables.html

http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Financing-and-Reimbursement/Provider-Preventable-Conditions.html

http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalAcqCond/index.html?redirect=/hospitalacqcond/

http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalAcqCond/Downloads/FY_2013_Final_HACsCodeList.pdf

http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalAcqCond/index.html?redirect=/HospitalAcqCond/06_Hospital-Acquired_Conditions.asp