AmeriHealth Caritas Louisiana

Health Care-Acquired Conditions

Reimbursement Policy ID: RPC.0044.2100

Recent review date: 12/2024

Next review date: 08/2025

AmeriHealth Caritas Louisiana 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. AmeriHealth Caritas Louisiana 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.

Conditions that are considered to be HACs/HCACs, Never Events, or Other Provider-Preventable Conditions 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
- Never Events/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

The following facility types do not report Present on Admission (POA) indicators and are exempt from the HAC payment provision.

1. Critical Access Hospitals (CAHs)
2. Long-term Care Hospitals (LTCHs)
3. Maryland Waiver Hospitals*
4. Cancer Hospitals
5. Children's Inpatient Facilities
6. Religious Non-Medical Health Care Institutions
7. Inpatient Psychiatric Hospitals
8. Inpatient Rehabilitation Facilities
9. Veterans Administration/Department of Defense Hospitals

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

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. These indicate whether the diagnosis was present on admission to acute care. Medicaid will require the Present-on-Admission (POA) indicators as listed below with all reported diagnosis codes. 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 as present on admission. 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

Code	Description
Y	Diagnosis was present at time of inpatient admission.
N	Diagnosis was not present at time of inpatient admission.
U	Documentation insufficient to determine if the condition was present at the time of inpatient admission.
W	Clinically undetermined. Provider unable to clinically determine whether the condition was present at the time of inpatient admission.

AmeriHealth Caritas Louisiana will determine if the HCAC was the cause for any additional days added to the length of stay. The plan may not reimburse for services related to HCAC. For per diem payments the number of covered days shall be reduced by the number of days associated with diagnoses Not Present on Admission for any HAC. The number of reduced days shall be based on the average length of stay (ALOS) on the diagnosis tables published by the International Classification of Diseases (ICD) vendor used by the Louisiana Medicaid Program. For example, an inpatient claim with 45 covered days identified with an HAC diagnosis having an ALOS of 3.4, shall be reduced to 42 covered days. This may result in a lower payment.

Payment may be adjusted if the 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 transfusions 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 Conditions. 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).
II. Healthcare Common Procedure Coding System (HCPCS).
III. International Classification of Diseases, 10th revision, Clinical Modification (ICD-10-CM) and associated publications and services.
IV. Centers for Medicare and Medicaid (CMS), https://www.cms.gov/medicare/payment/fee-for-service-providers/hospital-aquired-conditions-hac
V. Centers for Medicare and Medicaid (CMS), https://www.cms.gov/files/document/fy-2023-icd-10-cm-coding-guidelines.pdf.
VI. 42 CFR 447, Subpart A.
VII. https://ldh.la.gov/assets/medicaid/Manuals/MCO_Manual.pdf.

Attachments

N/A

Associated Policies

N/A

Policy History

06/2025	Minor updates to formatting and syntax
04/2025	Revised preamble
12/2024	Reimbursement Policy Committee approval
08/2024	Annual review • Updated Edit Source
04/2024	Revised preamble
12/2023	Reimbursement Policy Committee approval
08/2023	Removal of policy implemented by AmeriHealth Caritas Louisiana from Policy History section
01/2023	Template revised • Preamble revised • Applicable Claim Types table removed • Coding section renamed to Reimbursement Guidelines • Associated Policies section added
	Precedes Act 319