PCHP Reimbursement Policy		
Topic: Health Acquired Conditions	Policy Number: PCHP.RI.005	Policy Section: Coding
Last Modification Date:	Effective Date: 5/15/2025	

Policy Disclaimer:

Please ensure adherence to correct billing and submission protocols. Utilize industry-standard, compliant codes when submitting claims. Services should be coded using Current Procedure Terminology® (CPT), Healthcare Common Procedure Coding System (HCPCS), and/or revenue codes. These codes specify the services or procedures rendered and must be fully substantiated in the medical record or office notes upon billing. Our reimbursement policies apply uniformly to both participating and non-participating professional providers and facilities, unless stated otherwise.

Failure to comply with appropriate coding/billing guidelines or current reimbursement policies may result in actions by PCHP, including claim rejection or denial, claim payment recovery/recoupment, or reimbursement adjustment to accurately reflect the services provided.

These reimbursement policies are designed to support you in submitting accurate claims and to clarify the criteria for reimbursement if PCHP covers the service under the member's benefit plan; however, coverage determination for items such as, but not limited to service, procedure, item, do not guarantee reimbursement. All billed services must align with authorization and medical necessity guidelines.

These reimbursement policies may be overridden by mandates in provider contracts, state or federal regulations, or Centers for Medicare & Medicaid Services (CMS) requirements. PCHP strives to implement policy changes promptly; any delays may necessitate recoupment of claims payment to the effective date as outlined in the policy. We reserve the right to periodically review and update these policies as needed, with the most current version available on our website upon any revisions.

Policy:

PCHP complies with Health Acquired Conditions and Provider Preventable Condition payment requirements in accordance with State and Federal requirements. PCHP will not reimbursement Provider Preventable Conditions (PPC) unless provider, state, federal, or CMS contracts and/or requirements indicate otherwise. PPCs are defined as the following:

- Hospital Acquired Conditions (HAC)
- Other Provider Preventable Conditions or Provider Preventable Conditions (referred to as PPC)

PCHP mandates the inclusion of Hospital-Acquired Condition (HAC) identifiers by submitting a Present on Admission (POA) indicator for all diagnoses on inpatient facility claims as specified by CMS. POA indicators must accompany both primary and secondary diagnoses on inpatient claims. Failure to

include the POA indicator with these codes may lead to claim denial or rejection. However, the admitting diagnosis does not require a POA indicator.

If a POA indicator identifies a HAC, associated charges and/or days will be excluded from the claim when calculating DRG reimbursement for inpatient services. It is possible to have multiple Complications or Comorbidities or Major Complications or Comorbidities reported on a claim. Only those identified as HACs will be excluded from the DRG calculation. In cases where a CC or MCC is not designated as a HAC, assignment to a higher-paying DRG may occur, potentially resulting in reduced reimbursement for non-DRG based services due to the presence of a HAC.

Reimbursement will not be reduced or denied if a condition defined as a HAC existed prior to treatment initiation at the facility. If a HAC is caused by one facility (primary), reimbursement will not be denied to a secondary facility that treats the HAC.

PCHP will adopt any future categories and/or conditions recognized as HACs by CMS or the state, or changes to the grouper algorithm.

Preventable Conditions:

PCHP identifies Provider Preventable Conditions (PPC) as a surgical or invasive procedure, or services related to such procedures, performed erroneously. For professional providers and facilities, procedures categorized as PPCs, along with related services, will be subject to rejection or denial. PCHP's definition of PPCs aligns with Centers for Medicare & Medicaid Services (CMS) guidelines, which include:

- Surgical or invasive procedures performed on the wrong body part.
- Surgical or invasive procedures performed on the wrong patient.
- Incorrect surgical or invasive procedures performed on a patient.

Providers are advised to use appropriate codes to report PPCs. In the event of erroneous surgical events during an inpatient stay, they should be documented on Type of Bill 0110 (no-pay claim) along with all associated services or procedures. All other inpatient procedures and services should be submitted separately on a distinct claim. A condition defined as an PPC for a member existing prior to the initiation of treatment by another provider will not impact that provider’s reimbursement.

Applicable Coding:

Code	Diagnosis	Description
PA	Y65.53	Surgical or invasive procedure on the wrong body part
PB	Y65.52	Surgical or invasive procedure on the wrong patient
PC	Y65.51	Wrong surgery or invasive procedure on patient

POA Indictor Table:

POA Indicator	Definition
Y	Diagnosis was present at time of inpatient admission.
N	Diagnosis was not present at time of inpatient admission.
U	Documentation is insufficient to determine if 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.
1	Unreported/Not used. Exempt from POA reporting. This code is the equivalent of a blank on the UB-04; however, it was determined that blanks were undesirable on Medicare claims when submitting this data via the /00410A

POA Exempt Facilities:

- Critical Access Hospitals (CAHs)
- Long-Term Acute Care hospitals (LTACs)
- Inpatient psychiatric hospitals • Inpatient rehabilitation facilities
- Maryland waiver hospitals
- Cancer hospitals
- Children's inpatient facilities
- Religious non-medical health care institutions
- Veterans Administration/Department of Defense hospitals

Health Acquired Condition Categories (HAC):

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
    a. Diabetic Ketoacidosis
    b. Nonketotic Hyperosmolar Coma
    c. Hypoglycemic Coma
    d. Secondary Diabetes with Ketoacidosis
    e. Secondary Diabetes with Hyperosmolarity
7. Catheter-associated Urinary Tract 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
    a. Laparoscopic Gastric Bypass

   b. Gastroenterostomy
   c. Laparoscopic Gastric Restrictive Surgery
11. Surgical Site Infection Following Certain Orthopedic Procedures
   a. Spine
   b. Neck
   c. Shoulder
   d. Elbow
12. Surgical Site Infection Following Cardiac Implantable Electronic Device (CIED)
13. Deep Vein Thrombosis (DVT)/Pulmonary Embolism (PE)
   a. Total knee replacement
   b. Hip replacement
14. Latrogenic Pneumothorax with Venous Catheterization

* Includes all injuries related to falls and trauma

**DVT/PE following total knee replacement or hip replacement in pediatric and obstetric patients is excluded from HCAC for Medicaid.

References:

This policy has been developed through consideration of the following:

CMS, Department of Health and Human Services, Texas Health and Human Services and all applicable agencies, National Correct Coding Initiative, National Uniform Billing Committee (NUBC), Code of Federal Regulations (CFR) Subpart A-Payments §447.26, Federal Register Vol. 76, No. 108- A. The Medicare Program and Quality Improvements Made in the Deficit Reduction Act of 2005 (DRA) (Pub. L. 109–171) and E. Section 2702 of the Affordable Care Act.

Policy History:

Description	Date
Policy Created	May 9, 2024
Policy Approved	January 30, 2025