

Hospital Acquired Conditions Payment Policy

Policy

The Plan will not reimburse for Hospital Acquired Conditions and will follow the list of Hospital Acquired Conditions (HAC) identified by the Centers for Medicare and Medicaid Services (CMS) in the Inpatient Prospective Payment System (IPPS) payment provision.

Definitions

Present on admission (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.

Reimbursement

Providers may not receive additional payment for cases where one of the identified HACs was not present on admission or when documentation is insufficient to determine if the condition was present at the time of admission.

Referral/notification/prior authorization requirements

POA indicator reporting is mandatory for all claims involving inpatient admissions to general acute care hospitals or other facilities.

Billing/coding guidelines

The POA indicator must be assigned to report present on admission information for both primary and secondary diagnoses when submitting information for inpatient services.

POA Indicator	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 condition was present at the time of inpatient admission.
W	Clinically undetermined. Unable to clinically determine whether or not the condition was present at the time of inpatient admission or not.
1	Exempt from POA reporting. This indicator is the equivalent of a blank on the UB-04.

Place of service

This policy applies to services rendered in the inpatient setting (POS 21) in general acute care hospitals or other facilities.

Policy history

Origination date: 09/01/09
Previous revision date(s): 09/01/2012 - Updated language in the reimbursement, billing/coding, and place of service sections.
05/01/2014 - Updated to refer to CMS list rather than listing all conditions and diagnosis codes.
09/01/2015 - Annual review and moved to new Plan template.
07/01/2016 - Annual review.

Connection date & details: May 2017 – Annual review.
 July 2018 – Annual review, no updates.
 July 2019 – Annual review, no updates.

The criteria listed above apply to Fallon Health plan and its subsidiaries. This payment policy has been developed to provide information regarding general billing, coding, and documentation guidelines for the Plan. Even though this payment policy may indicate that a particular service or supply is considered covered, specific provider contract terms and/or member individual benefit plans may apply and this policy is not a guarantee of payment. The Plan reserves the right to apply this payment policy to all of the Plan companies and subsidiaries. The Plan routinely verifies that charges billed are in accordance with the guidelines stated in this payment policy and are appropriately documented in the medical records. Payments are subject to post-payment audits and retraction of overpayments.