Reimbursement Policy

Effective Date: 09/28/2017
Reimbursement Policy Number: R19

Hospital Acquired Conditions

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Related Policies

R05 Never Events

INSTRUCTIONS FOR USE

Reimbursement policies are intended to supplement certain standard benefit plans. Please note, the terms of an individual's particular benefit plan document [Group Service Agreement (GSA), Evidence of Coverage, Certificate of Coverage, Summary Plan Description (SPD) or similar plan document] may differ significantly from the standard benefit plans upon which a reimbursement policy is based. For example, an individual's benefit plan document may contain specific language which contradicts the guidance outlined in a reimbursement policy. In the event of a conflict, an individual's benefit plan document always supersedes the information in a reimbursement policy. Reimbursement terms in agreements with participating health care providers may also supersede the information in a reimbursement policy. Proprietary information of Cigna. Copyright ©2018 Cigna

Overview

Cigna's policy on hospital acquired conditions is designed to encourage hospitals to improve patient safety and reduce avoidable error rates.

Hospital acquired conditions which were not present on admission are reasonably preventable through the application of appropriate evidence-based protocols. Hospital acquired conditions may result in more serious outcomes to the patient, including death, loss of function, and disability. Hospital acquired conditions may also lead to longer lengths of stay or delays in discharge.

Reimbursement Policy

Cigna does not provide reimbursement for hospital acquired conditions as defined in this policy when permitted by contract.

This policy, along with provider contracting initiatives and provider transparency strategies, is intended to improve hospital reporting, help reduce the number of these events, assist the member in becoming more informed regarding hospital quality issues and to more closely align our practices with CMS (Centers for Medicare and Medicaid Services).

Cigna requires the Present on Admission (POA) indicator for all claims involving inpatient admissions to general acute care hospitals or other similar facilities. This requirement does not apply to Critical Access Hospitals, Rehabilitation Hospitals, Psychiatric Hospitals, or any other facility not paid under Medicare Hospital IPPS including Maryland Hospitals.

Cigna reserves the right to return any claim without a POA indicator. In addition, as part of Cigna's Quality Management Program, Cigna may request additional medical records for admissions involving Never Events and hospital acquired conditions, not present on admission.
General Background

The Leapfrog Group, founded in 2000, is an employer-led group of more than 145 organizations “that sponsor health care benefits and support the use of their purchasing power to initiate breakthrough improvements in the safety, quality and affordability of health care”. Based on the National Quality Forum (NQF) “never events” definition (which differs from Cigna’s definition), the Leapfrog Group encourages hospitals to adhere to the following initiatives:

- Apologize to the patient and/or family affected by the never event;
- Report the event to at least one of the following agencies: the Joint Commission, a state reporting program for medical errors; a Patient Safety Organization.
- Perform a root cause analysis consistent with instructions from the chosen reporting agency, and
- Waive all costs directly related to the serious reportable adverse event.

The National Quality Forum, a private organization whose members include the American Medical Association (AMA), defines “never events” as “errors in medical care that are clearly identifiable, preventable, and serious in their consequences for patients, and that indicate a real problem in the safety and credibility of a health care facility”.

In order to be included in the NQF list of “never events”, the following criteria must be met:

- “Unambiguous – clearly identifiable and measurable, and thus feasible to include in a reporting system;
- Usually preventable – recognizing that some events are not always avoidable, given the complexity of health care;
- Serious – resulting in the death or loss of a body part, disability, or more than transient loss of a body function, and
- Any of the following:
  - Adverse and/or
  - Indicative of a problem in the health care facility’s safety systems and/or, important for public credibility or public accountability.”

Hospital Acquired Conditions

Hospital acquired conditions (a.k.a. avoidable hospital conditions) as defined by NQF are conditions “which could reasonably have been prevented through application of evidence-based guidelines.” These conditions are not present when patients are admitted to a hospital, but present during the course of the stay.

Using the criteria developed by NQF, and working with other groups, including providers to identify quality standards that can be a basis for public reporting and payment, the Centers for Medicare and Medicaid Services (CMS) launched a number of initiatives to improve the quality of health care. These initiatives were taken as a result of the Deficit Reduction Act (DRA) of 2005, Section 5001 C. Under the DRA, CMS was required to select conditions that were consistent with the following:

- High cost, high volume, or both;
- Assigned to a higher paying DRG when present as a secondary diagnosis;
- Reasonably prevented through the application of evidence-based guidelines.

On August 1, 2007, CMS issued a final rule to end payment for the extra care resulting from certain medical mistakes (e.g. hospital acquired conditions (HAC)) effective October 1, 2008. The CMS rule also prohibits passing these charges on to patients. The conditions will be handled at the lower paying DRG when the condition is not present on admission and is the only major complication/co-morbidity (MCC)/complication/comorbidity (CC) reported. If other secondary diagnoses that are MCC/CC are reported, Medicare will process the admission at the appropriate higher level DRG.

The HAC conditions in the initial CMS ruling and effective October 1, 2008, were as follows:

- foreign objects retained after surgery,
- air embolism,
- blood incompatibility,
• pressure ulcers stages III & IV,
• falls and trauma,
• catheter associated urinary tract infection,
• vascular catheter-associated infection and surgical site infection, and
• mediastinitis, following coronary artery bypass graft (CABG)

In the August 19, 2008 the final rule posted in the Federal Register, CMS added additional conditions subject to payment at the lower DRG level if not present on admission effective October 1, 2008. These conditions included the following:
• manifestations of poor glycemic control,
• surgical site infection following certain orthopedic procedures,
• surgical site infection following bariatric surgery for obesity, and
• deep vein thrombosis and pulmonary embolism following certain orthopedic procedures.

Example: A 60 year old female is admitted for a spinal fusion of the lumbar spine. Post-surgery, the patient is found to be anemic and requires a blood transfusion. The patient is given the wrong blood type. (ICD-10 CM T80.3 series). This patient has no other major complications or comorbidities. Due to the reaction to the incompatible blood (hospital acquired condition), the patient’s length of stay is prolonged an additional two hospital days. In this case, the additional two inpatient days required as a direct result of the hospital acquired condition (not present on admission) could potentially be denied as a delay in discharge if the provider contract supports such a payment denial, or according to policies, procedures and directives applicable to contracted providers.

Present on Admission
CMS provided that effective October 1, 2007; hospitals should begin submitting inpatient hospital charges with a Present on Admission (POA) indicator. Present on admission is defined as a condition that is present at the time the order for inpatient admission occurs. Conditions that develop during an outpatient encounter, including the Emergency Department, observation or outpatient surgery, are considered as present on admission.

The provision does not apply to Critical Access Hospitals, Rehabilitation Hospitals, Psychiatric Hospitals, or any other facility not paid under Medicare Hospital IPPS including Maryland Hospitals.

The POA indicator is applicable to both the primary and secondary diagnosis as well as the external cause of injury codes. Categories and codes exempt from reporting are late effect codes, normal delivery, Z-codes, and certain external codes (e.g. railway, motor vehicle, water transport, air and space transport).

The POA indicator is submitted in field 67 of the UB-04 and in segment K3 in the 2300 loop, data element K301 for the 4010A1 version of the 837i electronic claim submission. The values for these fields are as follows:

Y = Present at the time of inpatient admission
N = Not present at the time of inpatient admission
U = Documentation is insufficient to determine if condition is present on admission
W = Provider is unable to clinically determine whether condition was present on admission or not
1 = Exempt from POA reporting. Unreported/Not used. This code is the equivalent code of a blank on the UB-04, however, it was determined that blanks are undesirable when submitting this data via the 4010A.
Z = The last secondary diagnosis indicator is followed by the letter “Z” to indicate the end of the data element.

To assist with the assignment of the POA indicator, see Appendix I Present on Admission Reporting Guidelines which is a supplement to the ICD-10-CM Official Guidelines for Coding and Reporting at https://www.cdc.gov/nchs/icd/icd10cm.htm

Per the CMS Manual System Publication 100-20 One-Time Notification, Transmittal 756, Change Request 7024, dated August 13, 2010:
“Effective with the implementation of 5010, Inpatient Prospective Payment System (IPPS) hospitals shall no longer report the POA indicator of “1”. ICD-9-CM diagnosis codes that are exempt from the POA reporting requirement shall not report a POA indicator. For calendar year 2011, the CMS will not allow a POA indicator of “1” to be submitted via direct data entry (DDE) claims.”

**Concurrent Review:**

We review admissions with identifiable hospital acquired conditions. If it is determined there were additional hospital inpatient days at a participating provider facility which directly and exclusively resulted from an hospital acquired condition (not present on admission), reimbursement for such additional inpatient days may be denied when permitted by the terms of the facility’s provider contract, or according to policies, procedures and directives applicable to contracted providers. Denials for inpatient hospital days which are the result of a delay in discharge due to inadequate nursing staff or procedure, or in violation of policies, procedures and directives applicable to contracted providers, are not billable to the member under the terms of most Cigna hospital contracts. These reimbursement denials will not apply to hospital admissions in which the hospital acquired condition was present on admission, or where another secondary diagnosis is a major complication/co-morbidity (MCC)/complication/co-morbidity (CC) in addition to the POA diagnosis, and potentially impacted the hospital acquired condition.

**Provider Transparency:**

Cigna believes our members should have access to information concerning hospital quality and safety. Information concerning mortality rates, hospital complications, patient safety, and participation in National Quality Forum’s Leapfrog Initiatives are included in Cigna's hospital quality tool available on Cigna's website for our members. For more information, see Cigna's website at: http://cigna.benefitnation.net/cignams/searchhosp.asp.

Hospitals are encouraged to adopt the Leapfrog Group’s policies on patient safety to help reduce hospital errors and improve the quality and affordability of health care. To review the Leapfrog Hospital Quality and Safety Survey, or to determine if a hospital has implemented one or more patient safety standards outlined by the Leapfrog Group, click on the following link: http://www.leapfroggroup.org/cp.

**Coding/Billing Information**

**General Reporting Requirements**

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

The provision does not apply to Critical Access Hospitals, Rehabilitation Hospitals, Psychiatric Hospitals, or any other facility not paid under Medicare Hospital IPPS including Maryland Hospitals.

**Coding for Conditions Present on Admission:**

In order to identify and monitor hospital acquired conditions, the inclusion of the appropriate ICD-10 CM code and Present on Admission (POA) indicator are required on claims submitted to Cigna. All hospitals should code claims submitted to Cigna with Present on Admission indicators. This information should be included in field -67 of the UB-04 paper claim and in segment K3 in the 2300 loop, data element K301 for the 837I electronic claim submission. With the implementation of 5010, effective January 2011, the POA indicators will follow the diagnosis code in the appropriate 5010 version 837i 2300 HI segment. Since October 1, 2008, Cigna has reserved the right to return any claim without a POA indicator. In addition, as part of Cigna’s Quality Management Program, Cigna may request additional medical records for admissions involving hospital acquired conditions, not present on admission.
In administering this policy, Cigna will seek to use published CMS Medicare guidelines, whenever such are consistent with our benefit plans and hospital contracts.

ICD-10 CODE LIST – EFFECTIVE 10/01/2017


References

7. CMS – Present on Admission Overview; Statute/Regulations/Program Instructions; Affected Hospitals; Reporting; Coding; Hospital Acquired Conditions Accessed January 2, 2008 at http://www.cms.hhs.gov/HospitalAcqCond/
9. CMS Regulation No. CMS -1390-P “Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2009”; Published 4/30/08; Accessed August 13, 2008 at: http://www.cms.hhs.gov/AcutelnpatientPPS/IPPS/itemdetail.asp?filterType=none&filterByDID=0&sortByDID=4&sortOrder=descending&itemID=CMS1209719&intNumPerPage=10
   https://www.cdc.gov/nchs/icd/icd10cm.htm


16. Major complication or co-morbidity (MCC) and complication or co-morbidity (CC) lists viewed online at:

17. MLN Matters MM5499 Revised, Effective October 1, 2007.; Accessed January 2, 2008 at:

18. National Quality Forum Updates Endorsement of Serious Medical Events in Healthcare, Accessed

   http://www.qualityforum.org/projects/completed/sre/

### Policy History/Update

<table>
<thead>
<tr>
<th>Date</th>
<th>Change/Update</th>
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<tbody>
<tr>
<td>10/04/2018</td>
<td>Updated policy template. Removed and updated references and link. Moved the summary section of previous template to the overview.</td>
</tr>
<tr>
<td>03/15/2018</td>
<td>Updated policy template. Removed references and link to ICD9 codes.</td>
</tr>
<tr>
<td>09/28/2017</td>
<td>Template and link to code list updated (added E1110 and E1111 to code list)</td>
</tr>
<tr>
<td>07/29/2016</td>
<td>Template updated</td>
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<tr>
<td>04/15/2014</td>
<td>Updated template. Added 999.32, 999.33, 539.01, 539.81, and 415.13 to the ICD9 diagnosis code list. Replaced coding section with coding links for both the ICD9 coding and the ICD10 translations which will be effective 10/15/2015.</td>
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<tr>
<td>12/04/2013</td>
<td>Updated template to include new logo</td>
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<tr>
<td>11/30/2010</td>
<td>Split out from Never Events policy. Changed title from Avoidable Hospital Conditions to Hospital Acquired Conditions in line with CMS. Updated ICD-9 CM coding section to reflect updated codes.</td>
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<tr>
<td>05/06/2009</td>
<td>Updated format. No policy changes</td>
</tr>
<tr>
<td>10/01/2008</td>
<td>Policy effective date for Cigna and former Great-West Healthcare network.</td>
</tr>
<tr>
<td>08/29/2008</td>
<td>Updated to include 4 additional conditions</td>
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<tr>
<td>04/15/2008</td>
<td>Notification date of policy for Cigna and former Great-West Healthcare network.</td>
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