healthfirst
Health Insurance for New Yorkers

Reimbursement Policy

Subject:	Hospital Acquired Conditions (HAC)		
Policy Number:	PO-RE-158v1		
Effective Date:	01/01/2025	**Last Approval Date:**	11/17/2025

I. Policy Description

Hospital Acquired Conditions (HACs) are serious conditions that develop during an inpatient hospital stay and are considered preventable when proper evidence-based procedures are followed. The Centers for Medicare and Medicaid Services (CMS), in collaboration with the Centers for Disease Control and Prevention (CDC), have identified a specific list of HACs for which additional reimbursement is not applicable under certain circumstances.

Healthfirst aligns its policy with guidelines established by the Centers for Medicare and Medicaid Services (CMS) and the Centers for Disease Control and Prevention (CDC). Accordingly, Healthfirst does not reimburse hospitals for additional costs related to HACs if they were not Present on Admission (POA). In such cases, the associated claims will be reimbursed as if the condition did not exist. Additionally, members must not be billed for any HACs acquired during hospitalization.

The information below applies to the following lines of business:

- Child Health Plus (CHP)
- Medicaid Managed Care (MMC)
- Medicare Advantage
- Medicare PPO
- Personal Wellness Plan (HARP)
- Essential Plan (EP)
- Managed Long Term Care Plan (MLTCP – Senior Health Partners)
- Medicaid Advantage Plus/MAP (CompleteCare)
- Qualified Health Plan (QHP)

Reimbursement Guidelines

Reimbursement determinations are also influenced by the Diagnosis-Related Group (DRG) design specific to each product line. Healthfirst has made a business decision to apply Medicaid APR-DRGs to Essential Plan (EP) and Qualified Health Plan (QHP) products.

- Hospitals will not receive additional payment for any of the listed HACs if they are not present on admission.
- Claims with HACs without a valid POA indicator of “Y” (Yes) will be reimbursed as though the condition was not present.

- These reimbursement rules apply only to IPPS (Inpatient Prospective Payment System) hospitals.
- Payment will be made to HACs when:
  - Y – The condition was present on admission
  - W – The condition could not be clinically determined as present on admission but is supported by documentation.

Billing Guidelines

Present on Admission (POA) Reporting

Hospitals must report a POA indicator for each diagnosis code on inpatient claims:
- UB-04 (paper claims): Field Locator 67 and 67 A–Q
- 837I (electronic claims): Per the UB-04 Data Specifications Manual

POA Indicator Codes:

Indicator	Description	Payment Status
Y	Diagnosis was present at the time of inpatient admission	Paid
N	Diagnosis was not present at time of admission	Not Paid
U	Documentation is insufficient to determine POA status	Not Paid
W	Clinically undetermined if present at admission	Paid
1	POA-exempt diagnosis code	Exempt

Note: POA Indicator “1” must not be used for any codes listed as HACs.

Documentation Requirements
- Accurate, complete medical record documentation is required for all coded diagnoses.
- Documentation must be provided by any licensed provider involved in the patient’s care.
- POA indicators must be appropriately sequenced and coded in alignment with ICD-10-CM and official coding guidelines.
- Billing offices and third-party agents are responsible for maintaining the integrity of code sequencing and POA accuracy.

HAC Categories Covered Under This Policy
1. Foreign Object Retained After Surgery
2. Air Embolism
3. Blood Incompatibility
4. Stage III & IV Pressure Ulcers
5. Falls and Trauma
6. Catheter-Associated Urinary Tract Infection (CAUTI)
7. Vascular Catheter-Associated Infection
8. Surgical Site Infection (SSI) – Mediastinitis after CABG
9. Poor Glycemic Control Manifestations
10. DVT/PE After Hip or Knee Replacement
11. SSI Following Bariatric Surgery
12. SSI Following Certain Orthopedic Procedures (Spine/Neck/Shoulder/Elbow)
13. SSI Following Cardiac Implantable Electronic Device (CIED)
14. Iatrogenic Pneumothorax with Venous Catheterization

Exempt Facilities

This policy does not apply to the following facility types:

- Critical Access Hospitals (CAHs)
- Long-Term Care Hospitals (LTCHs)
- Cancer Hospitals
- Children's Inpatient Facilities
- Religious Non-Medical Health Care Institutions
- Inpatient Psychiatric Hospitals
- Inpatient Rehabilitation Facilities
- Veterans Administration/Department of Defense Hospitals

Adjudication and Appeal Process

1. Reimbursement for inpatient services will be determined based on the provider's scope of services and the reimbursement rates outlined in the provider's contract with Healthfirst.

2. Claims submitted by providers that do not adhere to this policy will be denied or rejected. It is the responsibility of the provider to ensure claims are coded accurately.

3. If the line of business (LOB) is not mentioned in this policy, the services are not covered and not eligible for reimbursement.

4. This policy is a provider resource for understanding Healthfirst's reimbursement guidelines. It does not guarantee coverage or payment. Final reimbursement decisions depend on benefit coverage, state/federal mandates, medical necessity, and provider contract.

5. Claims submissions will be subject to timely filing requirements, as set forth in the provider contract with Healthfirst and in the Healthfirst Provider Manual. *Refer to: Healthfirst Provider Manual Subsection 17.6, "Claims Inquiries, Corrected Claims, Claim Reconsideration, and Appeal Process" in this section.*

For any questions or further clarification regarding this policy, providers are encouraged to reach out to their designated contact within our organization

II. Applicable Codes

Code	Description	Comment

III. Definitions

Term	Meaning
CAH	Critical Access Hospitals
LTCH	Long-Term Care Hospitals
LOB	Line of Business
POA	Present on Admission

IV. Related Policies

Policy Number	Policy Description
N/A	N/A

Procedure codes appearing in Reimbursement Policy documents are included only as a general reference tool for each policy. They may not be all-inclusive.

V. Reference Materials

Hospital-Acquired Conditions | CMS
New York State Medicaid Hospital-Acquired Conditions Policy
UB-04 Data Specifications Manual
ICD-10-CM Official Coding Guidelines
CMS Annual Present on Admission (POA) Exempt Code List

VI. Revision History

Revision Date	Summary of Changes

Disclaimer

Healthfirst's claim edits follow national industry standards aligned with CMS standards that include, but are not limited to, the National Correct Coding Initiative (NCCI), the National and Local Coverage Determination (NCD/LCD) policies, appropriate modifier usage, global surgery and multiple procedure reduction rules, medically unlikely edits, duplicates, etc. In addition, Healthfirst's coding edits incorporate industry-accepted AMA and CMS CPT, HCPCS and ICD-10 coding principles, National Uniform Billing Editor's revenue coding guidelines, CPT Assistant guidelines, New York State-specific coding, billing, and payment policies, as well as national physician specialty academy guidelines (coding and clinical). Failure to follow proper coding, billing, and/or reimbursement policy guidelines could result in the denial and/or recoupment of the claim payment.

This policy is intended to serve as a resource for providers to use in understanding reimbursement guidelines for professional and institutional claims. This information is accurate and current as of the date of publication. It provides information from industry sources about proper coding practice. However, this document does not represent or guarantee that Healthfirst will cover and/or pay for the services outlined. Reimbursement decisions are based on the terms of the applicable evidence of coverage, state and federal requirements or mandates, and the provider's participation agreement. This includes the determination of any amounts that Healthfirst or the member owes the provider.