Policy Information			
Policy Title	Provider Preventable Healthcare Acquired Conditions	**Current Version Publish Date**	10/2025
Policy Manual	Provider Reimbursement Policy Manual	**Original Effective Date**	10/2025
Policy Number	2	**Next Review Date**	Annual

Policy Applicability (LOB)			
☒Medicare Inc	☒Commercial IA	☒Commercial IL	☒Health Choices
☒Medicare WI	☒Commercial WI	☒CPPHP (Kansas)	

Policy Statement and Purpose

This policy addresses the criteria for reimbursement when Provider Preventable Healthcare Conditions resulted during the rendering of services during a facility encounter for inpatient facility claims. The stipulations are based on CMS payment guidelines. Adhering to best practices for patient care does not imply payment, only eligibility for reimbursement. Actual payment for services will be guided by the services documented in the medical record and the coverage criteria in the patient's contracted medical plan for whom the services are rendered.

This policy is expressly incorporated into and made a part of all reimbursement agreements and will provide context and clarity to the extent there is ambiguity in payment terms and notwithstanding contrary claims with regard to industry standards or practices

Policy Definitions

The terms described below will define their meaning and intent as it pertains to eligibility for reimbursement and payments made under this policy. In the event of legal or professional differences, the definitions for the terms stated herein will prevail notwithstanding, and requisite payment actions will be made accordingly.

ASC: Ambulatory Surgical Center

CMS: Centers for Medicare and Medicaid Services

CMS-1450: A standardized medical claim form, also known as the UB-04, used by institutional healthcare providers when requesting reimbursement for services and supplies provided to patients.

Hospital Acquired Condition (HAC): A condition that is not present when the patient arrives or is admitted to the hospital or other facility owned by the hospital but occurs during or after the stay.

IC: Iatrogenic Complication

Iatrogenic Complication: An adverse condition that is a direct result of treatment by a physician or other health care professional.

IPPS: Inpatient Prospective Payment System

Never Events (NE): Errors in medical care that are of a nature that the risk of occurrence is significantly influenced by the policies and procedure of the health care organization. These events when they occur are a concern to the public as well as the healthcare community.

Nosocomial Infection: An infection that develops while a person is receiving medical care in a healthcare facility.
POA: Present on Admission

PPHAC: Provider Preventable Healthcare Acquired Conditions
Qualified Healthcare Practitioner: Individual who is qualified by education, training, licensure/regulation (when applicable) and facility privileging (when applicable) who performs a professional service within his/her scope of practice and independently reports that professional service.

Type of Bill (TOB) 110: No pay inpatient claim. All services and supplies for the entire episode of care are provider liability.

UB-04: A standardized medical billing form used by facility providers to submit claims for reimbursement to insurance companies and governmental entities. It is also known as the CMS-1450.

Policy Provisions and Required Procedures

Due to the prevalence of *Provider Preventable Healthcare Acquired Conditions (PPHAC)*, in 2005 CMS took steps to identify and report medical errors, nosocomial infections, iatrogenic complications and accidents that occurred during a hospital encounter. In 2007 CMS began reducing payments to facilities where PPHACs occurred. It was determined that a key indicator of PPHAC is whether a condition was present upon admission to an inpatient facility. In that same year, CMS required the *Present on Admission (POA) Indicator Code* be assigned to all principle and secondary diagnostic codes on the UB-04 (CMS-1450) claim forms.

Medical Associates Health Plans (Health Plans) conform to CMS guidance in identifying the types of adverse health events that may result in claim payment reduction. Consistent with CMS, we make payment adjustments for instances of PPHAC as an incentive for facilities and Qualified Healthcare Practitioners to implement best practices that would improve all aspects of patient safety. Following are the PPHAC categories. Each category is explained below with relevant payment considerations.

- Hospital Acquired Conditions (HAC)
- Iatrogenic Complications (IC)
- Never Events (NE)

Hospital Acquired Conditions (HAC)

What conditions are considered HACs?

Healthcare Associated Infections (HAI)

- Central Line-Associated Bloodstream Infection (CLABSI)
- Surgical Site Infection (SSI), any
- Methicillin-resistant Staphylococcus Aureus (MRSA) Bacteremia
- Clostridium Difficile Infection (CDI)
- Pseudomonas Infections

Patient Safety and Adverse Events

- Pressure Ulcer (Stages III and IV)
- In-Hospital Fall resulting in fractures, dislocations, intracranial injuries
- Postoperative Acute Kidney Injury Requiring Dialysis
- Postoperative Respiratory Failure
- Postoperative Sepsis
- Postoperative Wound Dehiscence
- Postoperative Hemorrhage/Hematoma
- Postoperative Pulmonary Embolism (PE)
- Deep Vein Thrombosis (DVT)
- Trauma rendered by heating/cooling blankets (burns, frostbite)
- Manifestations of poor glycemic control

Is there payment for services that resulted in a HAC?

Our Health Plans will pay:

- Services and supplies that are unrelated to the HAC.
- Services of a facility or Qualified Healthcare Practitioner unrelated to the HAC when services are rendered in an attempt to correct, restore or repair the effects of a HAC caused by another facility or Qualified Healthcare Practitioner.

Our Health Plans will not pay:

Treatment or care of a rendering facility, practice group, or Qualified Healthcare Practitioner to correct, restore or repair the effects of a HAC that either it caused or its hospital subsidiary caused or a Qualified Healthcare Practitioner caused.

Coding Guidelines

When is the POA Indicator Required?

All inpatient facility claims, except those exempted, must report Present on Admission (POA) indicators.

Where should the POA Indicator be Reported?

The POA indicator should be reported for the primary and secondary diagnoses on line 67 and 67A, respectively, on the UB-04 (CMS1450).

Exemptions from POA Reporting

The following facilities are exempt from reporting a POA indicator:

- Critical Access Hospitals
- Rehabilitation hospitals and units
- Long-term care hospitals
- Children's hospitals
- Veterans Affairs hospitals

Assigning the POA Indicator

INDICATOR	DESCRIPTION
y	Diagnosis was present at time of admission to facility
N	Diagnosis was not present at time of admission to facility
W	Unable to determine if condition was present at time of admission to facility
U	Documentation insufficient to determine if condition was present on admission
1	Exempt from POA reporting

Iatrogenic Complications (IC)

What conditions are considered ICs?

- Air Embolism
- Iatrogenic Pneumothorax
- Perioperative Hemorrhage/Hematoma
- Abdominopelvic Accidental Puncture/Laceration
- Perioperative Pulmonary Embolism
- Perioperative Deep Vein Thrombosis
- Blood Incompatibility
- Foreign Object or Instruments Retained in the Body after Surgery
- Wrong Drug
- Improper Route of Drug Administration
- Improper Drug Administration

Is there payment for services that resulted in an IC?

Our Health Plans will pay:

- Services and supplies that are unrelated to the IC.

- Treatment or care of a rendering facility, practice group, or Qualified Healthcare Practitioner to correct, restore or repair the effects of an IC that neither it caused or its hospital subsidiary caused or a Qualified Healthcare Practitioner caused.

Our Health Plans will not pay:

- Treatment or care of a rendering facility, practice group, or Qualified Healthcare Practitioner to correct, restore or repair the effects of an IC that either it caused or its hospital subsidiary caused or a Qualified Healthcare Practitioner caused
  .
- Our Health Plans will not pay any portion of a facility claim or the claim of a Qualified Healthcare Practitioner where the death of a patient was the result of an IC. This is because neither the facility nor the

Qualified Healthcare Practitioner have adequate controls to ensure patient safety. These instances are provider liability and should be reported with Type of Bill 110 (No Pay/Provider Liable Claim).

Never Events (NE)

What conditions are considered Never Events?

- Wrong surgical or other invasive procedure performed on a patient
- Surgical or other invasive procedure performed on the wrong body part
- Surgical or other invasive procedure performed on the wrong patient
- Patient death or serious injury associated with administration of blood products
- Patient death from suicide (does not include suicide attempt or suicidal ideations)
- Kidnapping
- Lost custody of patient for a period of time during hospital stay

Is there payment for services that resulted in a Never Event?

There is no payment for any portion of an inpatient encounter that resulted in a Never Event. All services and supplies are provider liability.

EXCEPTIONS:

- If the Never Event was related to a surgery or procedure, our Health Plans will reimburse services and supplies prior to the surgery/procedure.

- If the Never Event was loss of custody of a patient for a period of time during the hospital encounter, reimbursement for services and supplies will depend on the state of the patient after the patient has been found. If the patient is found unharmed and with no exacerbation of the healthcare condition for which they were admitted and no new conditions have been acquired as a result of a temporary loss of custody, our Health Plans will pay for the services up to the loss of custody and immediately after custody is regained. No services or supplies will be paid for the time period that the patient could not be found and no services or supplies will be paid for exacerbation or newly acquired conditions resulting from the loss of custody.

How are inpatient encounters that result in a Never Event reported?

- Submit claim with Type of Bill 110 (No Pay/Provider Liable Claim).
- For claims with an exception, as noted above, bill Type of Bill 110 for the period that the hospital lost custody of the patient. Bill the remainder of the charges on a separate claim with the appropriate Type of Bill code.

How do outpatient facilities, ASCs and professional providers report Never Events?

Append the appropriate modifier to the charges associated with the surgical error.

MODIFIER	DESCRIPTION
PA	Surgery wrong body part
PB	Surgery wrong patient
PC	Wrong surgery on patient

Related Policies	
Related Training/ Job Aids	
NCQA Standard	

References	Hospital Acquired Conditions Reduction Program | CMS Hospital Acquired Conditions Present on Admission Indicator | CMS Report-Accuracy in Coding Present on Admission Indicators | CMS		
Exhibits			
Policy Owners / Reviewers			
Department Owner	Lisa Kuhls, Provider Relations Manager	**Date Reviewed**	10/1/2025
Department Reviewer	Network Strategy Committee	**Date Reviewed**	
Approving Committee if applicable	☐Compliance ☒UMC ☐QIC ☐Board of Directors ☐Other: _____	**Date Approved**	
History			
Date of revision	*Summary of changes* Prior Reviews: Revised: Reviewed:		