PAYMENT POLICY ID NUMBER: 21-074

Original Effective Date: 08/01/2021

Revised: 11/15/2024

Never Event – Hospital Acquired Condition (HAC) in Inpatient Setting

THIS PAYMENT POLICY IS NOT AN AUTHORIZATION, CERTIFICATION, EXPLANATION OF BENEFITS, OR A GUARANTEE OF PAYMENT, NOR DOES IT SUBSTITUTE FOR OR CONSTITUTE MEDICAL ADVICE. ALL MEDICAL DECISIONS ARE SOLELY THE RESPONSIBILITY OF THE PATIENT AND PHYSICIAN. BENEFITS ARE DETERMINED BY THE GROUP CONTRACT, MEMBER BENEFIT BOOKLET, AND/OR INDIVIDUAL SUBSCRIBER CERTIFICATE IN EFFECT AT THE TIME SERVICES WERE RENDERED. THIS PAYMENT POLICY APPLIES TO ALL LINES OF BUSINESS AND PROVIDERS OF SERVICE. IT DOES NOT ADDRESS ALL POTENTIAL ISSUES RELATED TO PAYMENT FOR SERVICES PROVIDED TO BCBSF MEMBERS AS LEGISLATIVE MANDATES, PROVIDER CONTRACT DOCUMENTS OR THE MEMBER'S BENEFIT COVERAGE MAY SUPERSEDE THIS POLICY. *THE EFFECTIVE DATE OF THIS POLICY DOES NOT CHANGE OUR STANDARD BILLING PROCESS THAT IS ALREADY IN PLACE BASED ON PARTICIPATION AGREEMENTS. THIS POLICY WAS CONTRACTUALLY APPLIED BEGINNING JANUARY 1, 2010*.

DESCRIPTION:

Florida Blue will begin applying this Policy for all commercial inpatient admissions soon, additional notification will be forthcoming. This policy applies to Florida Blue commercial inpatient acute care hospital claims. It applies to all participating acute care hospitals.

Hospital-Acquired Conditions (HAC)

Conditions identified by CMS that are (a) high cost, high volume, or both; (b) assigned to a higher paying diagnosis related grouping (DRG) when present as a secondary diagnosis; and (c) could reasonably have been prevented through the application of evidence-based guidelines. October 1, 2008, Medicare no longer assigned an inpatient hospital discharge to a higher paying MS-DRG if a selected HAC was not present on admission. That is, the case will be paid as though the secondary diagnosis was not present. Medicare will continue to assign a discharge to a higher paying MS-DRG if the selected condition was present on admission. The list of conditions can be revised over time. Florida Blue adopted the Centers for Medicare and Medicaid (CMS) list of HACs and uses the MS DRG Grouper in effect each year, so the same process applies to our members' inpatient acute care hospital claims.

It should be noted that it is possible to have more than one complication or comorbidity (CC) or major complication or comorbidity (MCC) reported on a claim. Only CCs or MCCs that are selected as HACs will be excluded when assigning the MS-DRG. In the event there is a CC or MCC reported that is not one of the HACs, the claim may still be assigned to the higher paying MS-DRG.

There are 14 categories of HACs listed below:

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
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
11. Surgical Site Infection Following Certain Orthopedic Procedures
12. Surgical Site Infection Following Cardiac Implantable Electronic Device (CIED)
13. Deep Vein Thrombosis (DVT)/Pulmonary Embolism (PE) Following Certain Orthopedic Procedures:
14. Iatrogenic Pneumothorax with Venous Catheterization

REIMBURSEMENT INFORMATION:

As noted above, Florida Blue uses CMS's MS DRG grouping logic which takes HACs and POAs into account for the DRG assignment process while also considering all secondary diagnosis codes billed for the admission. Corresponding payment reductions because of DRG assignment logic occur when the complicating DRG and its higher weight are not used for the DRG allowance calculation. Hospitals should not bill or attempt to collect from member any reduction in allowance due to a hospital acquired condition. All future HACs passed by CMS and incorporated into the CMS DRG Grouper will be incorporated into this policy commensurate with the CMS effective date. The DRG assignment logic only impacts those claims reimbursed at the DRG allowance. Other reimbursement methodologies for commercial inpatient acute care claims will follow the process outlined below.

Florida Blue must consider and include a HAC reduction process that applies to all our inpatient hospital reimbursement methods, and not just for DRG contracts but per diem contracts as well. Florida Blue will begin to assign two DRGs internally to all inpatient hospital claims for those acute care hospitals subject to CMS's Hospital Acquired Condition and Never Event policies. This will require a weight table to be chosen and defined even for per diem agreements. If a weight table is not defined, the Inpatient Prospective Payment System DRG Weight Table in effect for the admission's discharge date will be used to identify the HAC reduction amount. An actual and alternative DRG will be used for applicable inpatient claims during claim adjudication and pricing. The actual DRG will use the submitted POA information when assigning a DRG to a claim. The alternative DRG will use a default POA of a "Y" for all HAC diagnosis codes on the claim to determine if the claim's DRGs are different and thus a HAC reduction applies.

Florida Blue is already applying a HAC reduction for those inpatient claims reimbursed at the DRG inlier, include the DRG inlier in the reimbursement calculation, or use the DRG inlier in the reimbursement calculation process. For example, low stay calculated per diem uses the DRG inlier to determine the per day reimbursement applicable and the DRG assigned is based on the current CMS DRG assignment logic thus, a HAC reduction is currently applied for this payment method. Our second dollar high charge formula adds a portion of the total covered charges to the DRG inlier thus, a HAC reduction is currently applied to the outlier portion of the calculation. This reference is not inclusive of all the reimbursement methods that fall in this category.

Florida Blue will begin applying a HAC reduction for those inpatient claims that are reimbursed based on a percentage of covered charges.

Florida Blue will not apply a HAC reduction to those reimbursement methodologies that do not allow for increased reimbursement for a HAC or include any charge-based reimbursement to determine the allowed amount. Florida Blue will not apply a HAC reduction to those services subject to additional reimbursement based on the payment program. For example, under Per Diem agreement, implants are a carve-out subject to additional reimbursement. HAC reductions do not apply.

Example 1:

Example, DRG Contract High Charge Formula:
Actual DRG 282 – Acute myocardial infarction, alive w/out CC/MCC
DRG 282 weight 1.3267, DRG Inlier amount $10,262.02
Alternative DRG 281 – Acute myocardial infarction, alive w/CC
DRG 281 weight 1.7687, DRG Inlier amount $13,680.89
High Charge Threshold $103,379; Total Covered Charges $154,700
Weight Differential is 1.3267/1.7687 = 75%, (1-.75 = .25), or an allowance reduction of 25%
The base rule HAC reduction amount is captured based on DRG assignment logic.
The outlier allowed amount is 40% (154,700 – 103,379) = 40% (51,321) = $20,528.40
The outlier rule HAC reduction amount is .25 x 20,528.40 = $5,132.10
The HAC reduction for the claim is $5,132.10.

Example 2:

Example, DRG Contract High Stay Percent, weight table 1:
Actual DRG 282 – Acute myocardial infarction, alive w/out CC/MCC
DRG 282 weight 1.3267, High Trim Point is 14
Alternative DRG 281 – Acute myocardial infarction, alive w/CC
DRG 281 weight 1.7687
Length of Stay is 20 days: Total Covered Charges $154,700
Weight Differential is 1.3267/1.7687 = 75%, (1-.75 = .25), or an allowance reduction of 25%
The High Stay percent is 43%
The allowed amount prior to any reductions, 154,700 * .43 = $66,521.
The HAC reduction amount is .25* $66,521 = $16,630.25
The HAC reduction for the claim is $16,630.25.

BILLING AND CODING:

Present on Admission (POA) Indicator

Florida Blue currently requires that all acute care hospitals submit a POA indicator for each diagnosis code being reported on an inpatient claim. POA indicator information is needed to identify which conditions were acquired during the hospitalization and, therefore, subject to the HAC payment provision. Following are the POA indicators:

- Y - Yes, present at the time of inpatient admission
- N - No, not present at the time of inpatient admission
- W - Clinically undetermined, the provider is unable to clinically determine whether the condition was present at the time of inpatient admission or not
- U - Unknown, the documentation is insufficient to determine if the condition was present at the time of inpatient admission
- Blank - Unreported/Not Used/ Exempt from POA reporting.

GUIDELINE UPDATE INFORMATION:

08/01/2021	New policy
07/14/2022	Annual review, no changes
07/01/2023	Annual review, no changes
08/08/2024	Notice for implementation statewide with references to reimbursement calculations
11/14/2024	Modify the date of implementation / go live