**Insights to Coding and Data Quality**

# Changes to Hospital Acquired Conditions for FY2013

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The Inpatient Prospective Payment System (IPPS) fiscal year (FY) 2013 brought with it some changes to the Hospital Acquired Conditions (HACs). This article provides a brief history of HACs, how reimbursement and quality reporting can be affected by these conditions, and the changes that became effective for FY2013.

## History of HACs

The Deficit Reduction Act of 2005 (DRA) required a quality adjustment to the Medicare Severity Diagnostic Related Groups (MS-DRG) payments for preventable conditions that occurred during an inpatient admission. The Health and Human Services (HHS) Secretary was tasked to identify, no later than October 1, 2007, at least two conditions that were:

- High cost or high volume or both,
- Result in the assignment of a case to a higher paying MS-DRG when provided as a secondary diagnosis, and
- Could reasonably have been prevented through the application of evidence-based guidelines.

This quality adjustment began on October 1, 2008. Inpatient Prospective Payment System (IPPS) hospitals did not receive the higher MS-DRG payment for cases when one of the selected conditions is acquired during hospitalization. In other words, when one of the selected HAC ICD-9-CM codes is assigned to a case AND the diagnosis code has a present on admission indicator (POA) of no, the case would be reimbursed as if that condition was not present on the claim.

For example, a patient is admitted with a diagnosis of community acquired pneumonia and is treated with IV antibiotics. During the course of admission, the patient develops a urinary tract infection and the physician documents it as due to the Foley catheter. The MS-DRG would be assigned with the principal diagnosis of pneumonia, ICD-9-CM code 486. Secondary diagnoses of ICD-9-CM codes 996.64, infection/inflammation due to an indwelling urinary catheter, and 599.0, urinary tract infection, would also be assigned. Normally, ICD-9-CM codes 996.64 and 599.0 would reassign the MS-DRG to one that is higher paying; however, because the condition occurred after admission, the hospital provider does not receive the additional reimbursement for the HAC condition through the MS-DRG payment calculation.

CMS also uses HAC conditions for the Hospital Inpatient Quality Reporting (IQR) Program. CMS first posted hospital-specific data on HACs on the Hospital Compare Web site in October 2011. CMS continues to update HAC-specific data on Hospital Compare. Hospital Compare can be accessed at **<http://www.medicare.gov/hospitalcompare/?AspxAutoDetectCookieSupport=1>.**

## FY 2013 changes

In August 2012, CMS published the IPPS FY2013 Final Rule. The Final Rule discusses the addition of two new HAC categories, as well as the addition of two ICD-9-CM codes to an existing HAC category.

The two new HAC categories added by CMS for FY 2013 are:

- Surgical Site Infection Following Cardiac Implantable Electronic Device (CIED), and
- Iatrogenic Pneumothorax with Venous Catheterization

The new surgical site infection following CIED specifies that a HAC exists when code 996.61, infection/inflammation due to cardiac device/implant/graft, or code 998.59, other postoperative infection, is designated with a POA of no AND is assigned with one of the procedure codes for a cardiac implantable electronic device. The HAC for iatrogenic pneumothorax is triggered when diagnosis code 512.1, iatrogenic pneumothorax, is designated with a POA of no AND is coded with procedure code 38.93, venous catheterization.

CMS also added the following two codes to the existing Vascular Catheter-Associated Infection HAC category:

- 999.32, bloodstream infection due to central line, and
- 999.33, local infection due to central venous catheter

These are considered HACs when either of these diagnoses is coded with a POA indicator of no.

Additional information regarding HACs, as well as a complete listing of the HACs and their corresponding ICD-9-CM codes, is available by accessing **<http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalAcqCond/downloads/hacfactsheet.pdf>**.

HACs can have a significant impact on reimbursement. It is important for Providers to be aware of what conditions CMS has designated as HACs and how HACs can affect reimbursement. Documentation should reflect whether the condition was present on admission or whether the condition developed during admission. The physician should be queried when the documentation is unclear.

Coders should have an understanding of the HAC program, which diagnoses and procedures trigger HACs, and the importance of accurate POA assignment. Clinical documentation specialists should be aware of the HAC conditions and identify opportunities to clarify documentation that may be vague or ambiguous. Consider having a second-level review of all HACs identified. Awareness and on-going evaluation of identified HACs is essential to ensure proper payment and accurate quality reporting.

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