Amerigroup An Anthem Company	**Reimbursement Policy**

Subject: Other Provider Preventable Conditions		
Effective Date: **04/06/18**	Committee Approval Obtained: **04/06/18**	Section: **Administration**

*****The most current version of the reimbursement policies can be found on our provider website. If you are using a printed version of this policy, please verify the information by going to https://providers.amerigroup.com. Under Quick Tools, select Reimbursement Policies > Medicare. *****

These policies serve as a guide to assist you in accurate claim submissions and to outline the basis for reimbursement if the service is covered by a member's Amerigroup Medicare Advantage benefit plan. The determination that a service, procedure, item, etc. is covered under a member's benefit plan is not a determination that you will be reimbursed. Services must meet authorization and medical necessity guidelines appropriate to the procedure and diagnosis as well as to the member's state of residence. You must follow proper billing and submission guidelines. You are required to use industry standard, compliant codes on all claim submissions. Services should be billed with CPT® codes, HCPCS codes and/or revenue codes. The codes denote the services and/or procedures performed. The billed code(s) are required to be fully supported in the medical record and/or office notes. Unless otherwise noted within the policy, our policies apply to participating providers and facilities; a non-contracting provider who accepts Medicare assignment will be reimbursed for services according to the original Medicare reimbursement rates.

If appropriate coding/billing guidelines or current reimbursement policies are not followed, Amerigroup Medicare Advantage may:

- Reject or deny the claim.
- Recover and/or recoup claim payment.

Amerigroup Medicare Advantage reimbursement policies are developed based on nationally accepted industry standards and coding principles. These policies may be superseded by mandates in provider, state, federal or CMS contracts and/or requirements. System logic or setup may prevent the loading of policies into the claims platforms in the same manner as described; however, Amerigroup Medicare Advantage strives to minimize these variations.

Amerigroup Medicare Advantage reserves the right to review and revise our policies periodically when necessary. When there is an update, we will publish the most current policy to this site.

Policy	Amerigroup Medicare Advantage does not reimburse for other provider preventable conditions (OPPC) as identified by CMS contracts and/or requirements. Procedures identified as an OPPC will be rejected or denied. A condition defined as an OPPC for a particular

<table>
<tr><td></td><td>patient existing prior to the initiation of treatment for that patient by that provider will not impact that provider's reimbursement.
OPPC are defined and categorized as:

<table><tr><th>Description</th><th>Modifiers</th><th>ICD-10 diagnosis</th><th>Surgical error codes</th></tr><tr><td>Surgical or invasive procedure on the wrong body part</td><td>PA</td><td>Y65.53</td><td>MZ</td></tr><tr><td>Surgical or invasive procedure on the wrong patient</td><td>PB</td><td>Y65.52</td><td>MY</td></tr><tr><td>Wrong surgery or invasive procedure on patient</td><td>PC</td><td>Y65.51</td><td>MX</td></tr></table>
Erroneous surgical events occurring during an inpatient stay should be reflected on Type of Bill 0110 (no-pay claim) along with all services or procedures related to the surgery. All other inpatient procedures and services should be submitted on a separate claim.

Note: The PC modifier is defined as Wrong Surgery on a Patient. It should not be used to represent the professional component of a service. Claims that incorrectly use this modifier may be denied. Claims must be resubmitted as a corrected claim and indicate the appropriate coding for the service(s) rendered.</td></tr>
<tr><td>History</td><td>• Biennial review approved and effective 04/06/18: Policy language updated
• Biennial review approved 05/02/16: Policy language updated
• Initial approval and effective 01/01/15</td></tr>
<tr><td>References and Research Materials</td><td>This policy has been developed through consideration of the following:
• CMS
• State contract</td></tr>
<tr><td>Definitions</td><td>• General Reimbursement Policy Definitions</td></tr>
<tr><td>Related Policies</td><td>• Claims Requiring Additional Documentation
• Claims Submission — Required Information for Facilities
• Claims Submission — Required Information for Professional Provider
• Documentation Standards for Episodes of Care
• Global Surgical Package
• Present on Admission Indicator for Health Care-Acquired Conditions</td></tr>
<tr><td>Related Materials</td><td>• None</td></tr>
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