	Reimbursement Policy	
Subject: Preventable Adverse Events		
Effective Date: **05/27/20**	Committee Approval Obtained: **05/27/20**	Section: **Administration**

*****The most current version of our 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/TX**.*****

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 STAR+PLUS MMP (Medicare-Medicaid Plan) benefits. 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 both participating and nonparticipating providers and facilities.

If appropriate coding/billing guidelines or current reimbursement policies are not followed, Amerigroup STAR+PLUS MMP may:

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

Amerigroup STAR+PLUS MMP reimbursement policies for Amerigroup STAR+PLUS MMP 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 These policies may be superseded by mandates in provider, state, federal or CMS contracts and/or requirements.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 STAR+PLUS MMP strives to minimize these variations.

Amerigroup STAR+PLUS MMP 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 STAR+PLUS MMP does not reimburse for Preventable Adverse Events (PAEs) unless provider, state, federal or CMS contracts and/or requirements indicate otherwise. PAEs are defined as the following: • Hospital-acquired conditions and health care-acquired conditions (both referred to in this document as Health Care Acquired Conditions) • Other Provider Preventable Conditions

Health Care Acquired Conditions (HCAC)
Amerigroup STAR+PLUS MMP requires the identification of HCACs (see Exhibit C) through the submission of a Present on Admission (POA) indicator (see Exhibit A) for all diagnoses on inpatient facility claims as identified by CMS. If the POA indicator identifies an HCAC, the reimbursement for the episode of care may be reduced or denied.

POA indicators are required for all inpatient primary and secondary diagnoses. Failure to include the POA indicator with the primary and secondary diagnosis codes may result in the claim being denied or rejected. The POA indicator is not required on the admitting diagnosis. Unless noted in Exhibit B, this requirement applies to all facilities.

Reimbursement will not be reduced or denied if a condition defined as HCAC for a member existed prior to the initiation of treatment for that member by that provider. If an HCAC is caused by one facility (primary), payment will not be denied to the secondary facility that treated the HCAC.

Amerigroup STAR+PLUS MMP reserves the right to request additional records to support documentation submitted for reimbursement.

Note: Claims may be subject to clinical review for appropriate reimbursement consideration.

Other Provider Preventable Conditions (OPPC)
For professional providers and facilities, procedures identified as an OPPC and all related services will be rejected or denied. OPPCs are defined by CMS contracts and/or requirements and categorized as:

Description	Modifiers	ICD-10 Diagnosis
Surgical or invasive procedure on the wrong body part	PA	Y65.53
Surgical or invasive procedure on the wrong patient	PB	Y65.52
Wrong surgery or invasive procedure on patient	PC	Y65.51

Providers should use the appropriate codes to report OPPCs. 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.

	A condition defined as an OPPC for a particular member existing prior to the initiation of treatment for that member by that provider will not impact that provider's reimbursement. **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.

History	• Review approved and effective **05/27/20**: The following policies were retired and consolidated into one:
	  ○ Policy number 12-006: Other Provider Preventable Conditions
	  ○ Policy number 12-001: Present on Admission: Health Care Acquired Conditions

References and Research Materials	This policy has been developed through consideration of the following: • CMS • Texas Health and Human Services Commission (HHSC) • Amerigroup STAR+PLUS MMP contract with HHSC • Code of Federal Regulations Subpart A — Payments §447.26 • Federal Register Vol. 76, No. 108 — A. The Medicare Program and Quality Improvements Made in the Deficit Reduction Act of 2005 (Pub. L. 109-171) and E. Section 2702 of the Affordable Care Act
Definitions	• **General Reimbursement Policy Definitions**
Related Policies	• Claims Requiring Additional Documentation • Claims Submission — Required Information for Facilities • Claims Submission — Required Information for Professional Providers • Documentation Standards for Episodes of Care • Global Surgical Package for Professional Providers
Related Materials	• None

Exhibit A: Present on Admission Indicators and Description

Indicator	Description
Y	Diagnosis was present at time of inpatient admission
N	Diagnosis was not present at time of inpatient admission
U	Documentation is insufficient to determine if condition was present at the time of inpatient admission
W	Clinically undetermined; provider unable to clinically determine whether the condition was present at the time of inpatient admission
1	This code is the equivalent of a blank on the UB-04; however, it was determined that blanks were undesirable on Medicare claims when submitting this data via the 004010/00410A1. **Note**: The number 1 is no longer valid on claims submitted under the version 5010 format, effective January 1, 2011. The POA field will instead be left blank for codes exempt from POA reporting.

Exhibit B: Medicare Exempt Facilities

The following facilities are exempt from the reporting requirement as indicated; this applies to Medicare markets using Medicare POA methodology:

- Critical access hospitals
- Long-term acute care hospitals
- Inpatient psychiatric hospitals
- Inpatient rehabilitation facilities
- Cancer hospitals
- Children's inpatient facilities
- Religious non-medical health care institutions
- Veterans Administration/Department of Defense hospitals

Exhibit C: Health Care-Acquired Condition Categories

1. Foreign object retained after surgery
2. Air embolism
3. Blood incompatibility
4. Stage III and IV pressure ulcers
5. Falls and trauma[1]
6. Manifestations of poor glycemic control:
    a. Diabetic ketoacidosis
    b. Nonketotic hyperosmolar coma
    c. Hypoglycemic coma
    d. Secondary diabetes with ketoacidosis
    e. Secondary diabetes with hyperosmolarity
7. Catheter-associated urinary tract infection
8. Vascular catheter-associated infection
9. Surgical site infection following:
    a. Cardiac implantable electronic device
    b. Coronary artery bypass graft — mediastinitis
    c. Bariatric surgery:
        i. Laparoscopic gastric bypass
        ii. Gastroenterostomy
        iii. Laparoscopic gastric restrictive surgery
    d. Orthopedic procedures:
        i. Spine
        ii. Neck
        iii. Shoulder
        iv. Elbow
10. Deep vein thrombosis (DVT)/pulmonary embolism (PE)[2]:
    a. Total knee replacement
    b. Hip replacement
11. Iatrogenic pneumothorax with venous catheterization

1 Includes all injuries related to falls and trauma

2 DVT/PE following total knee replacement or hip replacement in pediatric and obstetric patients is excluded from HCAC for Medicaid.