UnitedHealthcare®

Reimbursement Policy

Wrong Surgical or Other Invasive Procedure Performed on a Patient (NCD 140.6)

Policy Number	140.6	Approved By	UnitedHealthcare Medicare Reimbursement Policy Committee	Current Approval Date	09/10/2014

IMPORTANT NOTE ABOUT THIS REIMBURSEMENT POLICY

This policy is applicable to UnitedHealthcare Medicare Advantage Plans offered by UnitedHealthcare and its affiliates.

You are responsible for submission of accurate claims. This reimbursement policy is intended to ensure that you are reimbursed based on the code or codes that correctly describe the health care services provided. UnitedHealthcare reimbursement policies use Current Procedural Terminology (CPT®*), Centers for Medicare and Medicaid Services (CMS), or other coding guidelines. References to CPT or other sources are for definitional purposes only and do not imply any right to reimbursement.

This reimbursement policy applies to all health care services billed on CMS 1500 forms and, when specified, to those billed on UB04 forms (CMS 1450). Coding methodology, industry-standard reimbursement logic, regulatory requirements, benefits design and other factors are considered in developing reimbursement policy.

This information is intended to serve only as a general resource regarding UnitedHealthcare's reimbursement policy for the services described and is not intended to address every aspect of a reimbursement situation. Accordingly, UnitedHealthcare may use reasonable discretion in interpreting and applying this policy to health care services provided in a particular case. Further, the policy does not address all issues related to reimbursement for health care services provided to UnitedHealthcare enrollees. Other factors affecting reimbursement may supplement, modify or, in some cases, supersede this policy. These factors may include, but are not limited to: legislative mandates, the physician or other provider contracts, and/or the enrollee's benefit coverage documents. Finally, this policy may not be implemented exactly the same way on the different electronic claims processing systems used by UnitedHealthcare due to programming or other constraints; however, UnitedHealthcare strives to minimize these variations.

UnitedHealthcare may modify this reimbursement policy at any time by publishing a new version of the policy on this Website. However, the information presented in this policy is accurate and current as of the date of publication.

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Application

This reimbursement policy applies to services reported using the Health Insurance Claim Form CMS-1500 or its electronic equivalent or its successor form, and services reported using facility claim form CMS-1450 or its electronic equivalent or its successor form. This policy applies to all products, all network and non-network physicians, and other health care professionals.

The HCPCS/CPT code(s) may be subject to Correct Coding Initiative (CCI) edits. This policy does not take precedence over CCI edits. Please refer to the CCI for correct coding guidelines and specific applicable code combinations prior to billing UnitedHealthcare. It is not enough to link the procedure code to a correct, payable ICD-9-CM diagnosis code. The diagnosis must be present for the procedure to be paid. Compliance with the provisions in this policy is subject to monitoring by pre-payment review and/or post-payment data analysis and subsequent medical review. The effective date of changes/additions/deletions to this policy is the committee meeting date unless otherwise indicated. CPT codes and descriptions are copyright 2010 American Medical Association (or such other date of publication of CPT). All rights reserved. CPT is a registered trademark of the American Medical Association. Applicable FARS/DFARS restrictions apply to Government use. Fee schedules, relative value units, conversion factors, and/or related components are not assigned by the AMA, are not part of CPT, and the AMA is not recommending their use. The AMA does not directly or indirectly practice medicine or dispense medical services. The AMA assumes no liability for data contained or not contained herein. Current Dental Terminology (CDT), including procedure codes, nomenclature, descriptors, and other data contained therein, is copyright by the American Dental Association, 2002, 2004. All rights reserved. CDT is a registered trademark of the American Dental Association. Applicable FARS/DFARS apply.

Summary

Overview

In 2002, the National Quality Forum (NQF) published “Serious Reportable Events in Healthcare: A Consensus Report" 1, which listed 27 adverse events that were “serious, largely preventable and of concern to both the public and health care providers.” These events and subsequent revisions to the list became known as “never events.” This concept and need for the proposed reporting led to NQF’s “Consensus Standards Maintenance Committee on Serious Reportable Events,” which maintains and updates the list which currently contains 28 items. Among surgical events on the list is “Wrong surgical procedure performed on a patient.” Similar to any other patient population, Medicare beneficiaries experience serious injury and/or death if wrong surgeries are performed and may require additional healthcare in order to correct adverse outcomes resulting from such errors.

Reimbursement Guidelines

Nationally Covered Indications

Not Applicable

Nationally Non-Covered Indications

The CMS does not cover a particular surgical or other invasive procedure to treat a particular medical condition when a practitioner erroneously performs a different procedure on a Medicare beneficiary because that particular surgical or other invasive procedure is not a reasonable and necessary treatment for the Medicare beneficiary’s particular medical condition.

A surgical or other invasive procedure is considered to be the wrong procedure if it is not consistent with the correctly documented informed consent for that patient. Emergent situations that occur in the course of surgery and/or whose exigency precludes obtaining informed consent are not considered erroneous under this decision. Also, the event is not intended to capture changes in the plan upon surgical entry into the patient due to the discovery of pathology in close proximity to the intended site when the risk of a second surgery outweighs the benefit of patient consultation; or the discovery of an unusual physical configuration (e.g., adhesions, spine level/extra vertebrae).

Surgical and other invasive procedures are defined as operative procedures in which skin or mucous membranes and connective tissue are incised or an instrument is introduced through a natural body orifice. Invasive procedures include a range of procedures from minimally invasive dermatological procedures (biopsy, excision, and deep cryotherapy for malignant lesions) to extensive multi-organ transplantation. They include

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all procedures described by the codes in the surgery section of the Current Procedural Terminology (CPT) and other invasive procedures such as percutaneous transluminal angioplasty and cardiac catheterization. They include minimally invasive procedures involving biopsies or placement of probes or catheters requiring the entry into a body cavity through a needle or trocar. They do not include use of instruments such as otoscopes for examinations or very minor procedures such as drawing blood.

CPT/HCPCS Codes

Unable to specify CPT/HCPCS codes due to "never events" may occur with any procedure.

Modifiers

Code	Description
PA	Surgical or other invasive procedure on wrong body part (NCD 140.7, ICD-9 E876.7, Condition Code MY)
PB	Surgical or other invasive procedure on wrong patient (NCD 140.8, ICD-9 E876.6, Condition Code MZ)
PC	Wrong surgery or other invasive procedure on patient (NCD 140.6, ICD-9 E876.5, Condition Code MX)

Condition Codes

Code	Description
MX	For a wrong surgery on patient (NCD 140.6, ICD-9 E876.5, Modifier PC)
MY	For surgery on the wrong body part (NCD 140.7, ICD-9 E876.7, Modifier PA)
MZ	For surgery on the wrong patient (NCD 140.8, ICD-9 E876.6, Modifier PB)

ICP/PCS Codes

Unable to specify ICP/PCS codes due to "never events" may occur with any procedure.

References Included (but not limited to):

CMS NCD(s)

NCD 140.6 Wrong Surgical or Other Invasive Procedure Performed on a Patient

Reference NCDs:

NCD 140.7 Surgical or Other Invasive Procedure Performed on the Wrong Body Part

NCD 140.8 Surgical or Other Invasive Procedure Performed on the Wrong Patient

CMS Benefit Policy Manual

Chapter 1; § 10 Covered Inpatient Hospital Services Covered Under Part A, § 120 Services Related to and Required as a Result of Services Which Are Not Covered Under Medicare

Chapter 16; § 10 General Exclusions From Coverage, § 180 Services Related to and Required as a Result of Services Which Are Not Covered Under Medicare

CMS Claims Processing Manual

Chapter 1; § 80.3.2.1.2 Conditional Data Element Requirements for A/B MACs and DMEMACs

Chapter 32; § 230 Billing Wrong Surgical or Other Invasive Procedures Performed on a Patient, Surgical or Other Invasive Procedures Performed on the Wrong Body Part, and Surgical or Other Invasive Procedures Performed on the Wrong Patient

CMS Transmittals

Transmittal 101, Change Request 6405, Dated 06/12/2009 (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)

Transmittal 1755, Change Request 6405, Dated 06/12/2009 (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)

Transmittal 1764, Change Request 6405, Dated 07/02/2009 (Rescinded and replaced by transmittal 1778

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dated July 24, 2009, to provide technical clarification to business requirements 6405.1.1, 6405.1.2, and 6405.1.4)

Transmittal 1778, Change Request 6405, Dated 07/24/2009 (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)

Transmittal 1819, Change Request 6405, Dated 09/25/2009 (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)

UnitedHealthcare Medicare Advantage Coverage Summaries

Hospital Services (Inpatient and Outpatient)

UnitedHealthcare Reimbursement Policies

Hospital Acquired Conditions

MLN Matters

Article MM6405 Revised, Wrong Surgical or Other Invasive Procedure Performed on a Patient; Surgery or Other Invasive Procedure Performed on the Wrong Body Part; and Surgical or Other Invasive Procedure Performed on the Wrong Patient

Article MM6718, Requirements to Prevent the Misuse of Modifiers PA, PB, and PC on Incoming Claims

History

Date	Revisions
09/10/2014	Annual review, no changes
06/26/2013	Annual review, no changes
05/23/2012	Administrative updates

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