BlueCross BlueShield Minnesota

MEDICAID REIMBURSEMENT POLICY

Wrong Surgical and Other Invasive Procedures

Active

Policy Number: Surgery/Interventional Procedure - 022
Policy Title: Wrong Surgical and Other Invasive Procedures
Section: Surgery/Interventional Procedure
Effective Date: 01/01/24

Description

This policy addresses reimbursement for services associated with a wrong surgical or other invasive procedures reported on either an institutional or professional claim.

Definitions

Surgical and other invasive procedures: 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 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.

Wrong procedure/wrong body part/wrong patient: A surgical or other invasive procedure is considered to be the wrong procedure, body part or patient if it is not consistent with the correctly documented informed consent for that patient.

Policy Statement

Blue Cross and Blue Shield of Minnesota and Blue Plus (Blue Cross) will not reimburse a surgical or other invasive procedure when the provider erroneously performs:

- A different procedure altogether.
- The correct procedure but on the wrong body part; or
- The correct procedure but on the wrong patient.

In addition, Blue Cross will not reimburse the following related services:

- All services provided in the operating room that are related to the error.
- All providers in the operating room when the error occurs, who could bill individually for their services.
- All related services provided during the same hospitalization in which the error occurred.

Following hospital discharge, necessary services are eligible for reimbursement regardless of whether they are or are not related to the surgical error.

Note: Related services do not include performance of the correct procedure.

Claim Submission Requirements

Inpatient Hospital:
For inpatient hospitalizations involving surgical errors, hospitals must separate the hospital stay into two claims:

- One claim with reimbursable service(s)/procedure(s) unrelated to the erroneous surgery(s) with a Type of Bill (TOB) 11X (with the exception of 110), and

- The second claim with the non-reimbursable service(s)/procedure(s) related to the erroneous surgery(s) with a TOB 110 (no-pay claim).

Both claims must have a matching Statement Covers Period.

The no-pay Type of Bill 110 claim must have one of the following ICD-10-CM diagnosis codes reported on the claim to identify the type of erroneous surgery performed:

- Y65.51 - Performance of wrong procedure (operation) on correct patient
- Y65.52 - Performance of procedure (operation) on patient not scheduled for surgery
- Y65.53 - Performance of correct procedure (operation) on wrong side of body parts

Hospital outpatient, ambulatory surgical centers (ASCs) and practitioners:
In addition to reporting the applicable ICD-10-CM code to identify the erroneous surgery performed, one of the following modifiers must be appended to all lines related to the surgical error:

- PA: Surgery Wrong Body Part
- PB: Surgery Wrong Patient
- PC: Wrong Surgery on Patient

Providers may not balance bill the patient for costs associated with erroneous procedures.

Documentation Submission

Documentation must identify and describe the services performed. If a denial is appealed, this documentation must be submitted with the appeal.

Coverage

Eligible services will be subject to the subscriber benefits, applicable fee schedule amount and any coding edits.

The following applies to all claim submissions.

All coding and reimbursement is subject to all terms of the Provider Service Agreement and subject to changes, updates, or other requirements of coding rules and guidelines. All codes are

subject to federal HIPAA rules, and in the case of medical code sets (HCPCS, CPT, ICD), only codes valid for the date of service may be submitted or accepted. Reimbursement for all Health Services is subject to current Blue Cross Medical Policy criteria, policies found in the Provider Policy and Procedure Manual sections, Reimbursement Policies and all other provisions of the Provider Service Agreement (Agreement).

In the event that any new codes are developed during the course of Provider's Agreement, such new codes will be paid according to the standard or applicable Blue Cross fee schedule until such time as a new agreement is reached and supersedes the Provider's current Agreement.

All payment for codes based on Relative Value Units (RVU) will include a site of service differential and will be calculated using the appropriate facility or non-facility components, based on the site of service identified, as submitted by Provider.

Coding

The following codes are included below for informational purposes only and are subject to change without notice. Inclusion or exclusion of a code does not constitute or imply subscriber coverage or provider reimbursement.

CPT/HCPCS Modifier:	PA	PB	PC
ICD-10 Diagnosis:	Y65.51	Y65.52	Y65.53
ICD-10 Procedure:	N/A		
CPT/HCPCS:	N/A		
Revenue Codes:	N/A		

Resources

Centers for Medicare and Medicaid Services (CMS) National Coverage Decision (NCD) 140.6 for Wrong Surgical or Other Invasive Procedures Performed on a Patient
CMS Pub 100-04 Medicare Claims Processing Transmittal 1819, Change Request 6405
Current Procedural Terminology (CPT®)
International Classification of Diseases, 10th Revision, Clinical Modification

Policy History

08/22/2023	Initial Committee Approval