

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

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[↪ Terms and Conditions](#)

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Related Medicare Advantage Policy Guidelines

- [Surgical or Other Invasive Procedure Performed on the Wrong Body Part \(NCD 140.7\)](#)
- [Surgical or Other Invasive Procedure Performed on the Wrong Patient \(NCD 140.8\)](#)

Related Medicare Advantage Coverage Summary

- [Hospital Services Inpatient and Outpatient](#)

Policy Summary

[↪ See Purpose](#)

Overview

In 2002, the National Quality Forum (NQF) published “Serious Reportable Events in Healthcare: A Consensus Report,” 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.

Nationally Non-Covered Indications

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 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.

Applicable Codes

The following list(s) of procedure and/or diagnosis codes is provided for reference purposes only and may not be all inclusive. Listing of a code in this guideline does not imply that the service described by the code is a covered or non-covered health service. Benefit coverage for health services is determined by the member specific benefit plan document and applicable laws that may require coverage for a specific service. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. Other Policies and Guidelines may apply.

Coding Clarification: Unable to specify CPT/HCPCS codes due to 'never events' which may occur with any procedure.

Modifier	Description
PC	Wrong surgery or other invasive procedure on patient

Bill Type	Description
110	Hospital, inpatient, non-payment/zero claim
11X	Covered service(s)/procedure(s) unrelated to the erroneous surgery(s) on a Type of Bill (TOB) 11X (with the exception of 110)

Diagnosis Code	Description
Y65.51	Performance of wrong procedure (operation) on correct patient

References

CMS National Coverage Determinations (NCDs)

[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 DME MACs and § 190 Payer Only Codes Utilized by Medicare](#)

[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 Transmittal(s)

[Transmittal 102, Change Request 6405, Dated 07/02/2009 \(Wrong Surgical or Other Invasive Procedure Performed on a Patient; Surgical or Other Invasive Procedure Performed on the Wrong Body Part; Surgical or Other Invasive Procedure Performed on the Wrong Patient\)](#)

[Transmittal 1819, Change Request 6405, Dated 09/25/2009 \(Wrong Surgical or Other Invasive Procedure Performed on a Patient; Surgical or Other Invasive Procedure Performed on the Wrong Body Part; Surgical or Other Invasive Procedure Performed on the Wrong Patient\)](#)

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](#)
[Article SE0927 Clarification of the Use of Modifiers When Billing "Wrong Surgery on a Patient"](#)

Guideline History/Revision Information

Revisions to this summary document do not in any way modify the requirement that services be provided and documented in accordance with the Medicare guidelines in effect on the date of service in question.

Date	Summary of Changes
04/01/2021	Template Update <ul style="list-style-type: none">Reformatted policy; transferred content to new template
08/12/2020	Applicable Codes <ul style="list-style-type: none">Removed Condition code MX Supporting Information <ul style="list-style-type: none">Updated <i>References</i> section to reflect the most current informationArchived previous policy version MPG354.05

Purpose

The Medicare Advantage Policy Guideline documents are generally used to support UnitedHealthcare Medicare Advantage claims processing activities and facilitate providers' submission of accurate claims for the specified services. The document can be used as a guide to help determine applicable:

- Medicare coding or billing requirements, and/or
- Medical necessity coverage guidelines; including documentation requirements.

UnitedHealthcare follows Medicare guidelines such as NCDs, LCDs, LCAs, and other Medicare manuals for the purposes of determining coverage. It is expected providers retain or have access to appropriate documentation when requested to support coverage. Please utilize the links in the [References](#) section below to view the Medicare source materials used to develop this resource document. This document is not a replacement for the Medicare source materials that outline Medicare coverage requirements. Where there is a conflict between this document and Medicare source materials, the Medicare source materials will apply.

Terms and Conditions

The Medicare Advantage Policy Guidelines are applicable to UnitedHealthcare Medicare Advantage Plans offered by UnitedHealthcare and its affiliates.

These Policy Guidelines are provided for informational purposes, and do not constitute medical advice. Treating physicians and healthcare providers are solely responsible for determining what care to provide to their patients. Members should always consult their physician before making any decisions about medical care.

Benefit coverage for health services is determined by the member specific benefit plan document* and applicable laws that may require coverage for a specific service. The member specific benefit plan document identifies which services are covered, which are excluded, and which are subject to limitations. In the event of a conflict, the member specific benefit plan document supersedes the Medicare Advantage Policy Guidelines.

Medicare Advantage Policy Guidelines are developed as needed, are regularly reviewed and updated, and are subject to change. They represent a portion of the resources used to support UnitedHealthcare coverage decision making. UnitedHealthcare may modify these Policy Guidelines at any time by publishing a new version of the policy on this website. Medicare source materials used to develop these guidelines include, but are not limited to, CMS National Coverage Determinations (NCDs), Local Coverage Determinations (LCDs), Medicare Benefit Policy Manual, Medicare Claims Processing Manual, Medicare Program Integrity Manual, Medicare Managed Care Manual, etc. The information presented in the Medicare Advantage Policy Guidelines is believed to be accurate and current as of the date of publication and is provided on an "AS IS" basis. Where there is a conflict between this document and Medicare source materials, the Medicare source materials will apply.

You are responsible for submission of accurate claims. Medicare Advantage Policy Guidelines are intended to ensure that coverage decisions are made accurately based on the code or codes that correctly describe the health care services provided. UnitedHealthcare Medicare Advantage Policy Guidelines 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 or guarantee claims payment.

Medicare Advantage Policy Guidelines are the property of UnitedHealthcare. Unauthorized copying, use, and distribution of this information are strictly prohibited.

*For more information on a specific member's benefit coverage, please call the customer service number on the back of the member ID card or refer to the [Administrative Guide](#).