Surgical "Never Events" Billing Related and Non-related Services

As a follow-up to last month's Current Developments' article titled "Reporting E-codes for Surgical 'Never Events,'" this article will further discuss the obligation on Medicare providers to list diagnosis codes on their claims. Specificallly, Medicare requires providers to report International Classification of Diseases, Ninth Revision Clinical Modification (ICD-9-CM) codes E876.5, E876.6, and E876.7 when filing claims for surgical "never events."[1] As specified in a National Coverage Decision (NCD) published on January 15, 2009, CMS will not reimburse a provider for services and/or procedures related to a "never event," i.e., the wrong operation on the correct patient, the operation on the wrong patient, or the operation on the wrong side or body part.[2]

The Centers for Medicare & Medicaid Services (CMS) recently issued guidance with respect to billing surgical "never events." CMS now requires hospitals to submit two inpatient claims when a surgical error, i.e. a surgical "never event," is rendered with covered services. CMS has informed providers that "Medicare will not cover hospitalizations and other services related to…non-covered procedures."[3] Further, CMS contractors will review beneficiaries' histories to identify claims related to the surgical "never event" every 30 days for an 18 month period from the date of the surgical error. Additionally, CMS contractors will "take appropriate action as necessary."[4] Thus, it is imperative for providers to understand how to distinguish and accurately claim related and non-related services and/or procedures when a surgical "never event" occurs since CMS contractors will routinely monitor claims and collect identified overpayments.

Related vs. Non-related Services

When a surgical error occurs, it is possible for additional services and/or procedures to be furnished during hospitalization. Some surgical errors will require additional hospital services to

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[1] E876.5 (performance of wrong operation (procedure) on correct patient); E876.6 (performance of operation (procedure on patient not schedule for surgery); and E876.7 (performance of operation (procedure on wrong side/body part).

[2] CMS, National Coverage Determination Manual, CMS 100-03, Ch. 1 sec. 140.6-140.8.

[3] "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." Medicare Transmittal 1819. 25 Sept. 2009.

[4] "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." MLN Provider Inquiry Assistance: JA6405.

treat conditions or complications due to the surgical errors, i.e. related services. Other hospital services may be necessary for conditions or complications not related to the surgical error, i.e. non-related services. Services that are related to a surgical "never events" are not reimbursed under Medicare. These services include:

- Services provided in the operating room when the surgical "never event" occurred;
- Services rendered by providers who can individually bill Medicare and who are present in the operating room during the surgical "never event;" and
- Services rendered during the hospitalization that are related to the surgical "never event."

It is important to note that services related to a surgical "never event" do not include the "performance of the correct procedure" or reasonable and necessary services following hospital discharged.[5] Thus, these services, as well as services not related to the surgical "never-event," are reimbursed by CMS if medically necessary and reasonable.

The following checklist was may assist in determining if a service is related or non-related to a surgical "never-event."

Related vs. Non-related Checklist		
YES	NO	
		Was the service provided in the operating room when the surgical "never event" occurred?
		Was the service furnished during the same hospitalization stay as the surgical "never event?"
		Was the service rendered by provider who can individually bill Medicare (e.g. anesthesiologists and radiologists) and was this provider present in the operating room during the surgical "never event?"

A response of "YES" indicates that the service is most likely related to the surgical "never event" and thus, is not covered by Medicare. Providers are strongly encouraged to review related medical records to ensure that documentation supports a submitted claim.

Billing Related and Non-related Services

CMS requires providers to submit two inpatient claims for related and non-related services when reporting a surgical "never event." Providers should submit type of bill (TOB) 110 for non-covered services and/or procedures and TOB 11X (where X does not equal 0) for covered services and/or procedures. Hospitals' billing personnel should verify that the stated cover periods reported on TOB 110 and 11X are the same. Furthermore, the billing department should ensure that the appropriate surgical "never event" code (ICD-CM-9 codes E876.5-

[5] "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." Medicare Transmittal 1819. 25 Sept. 2009.

E876.7) are reporting in diagnosis position 2 to 9 on TOB 110 since the Medicare Code Editor will not trigger edits beyond position 9.

The Importance of Accurate Billing

As noted above, CMS contractors will regularly review beneficiaries' histories over an 18 month period when a surgical "never event" has been reported. Additionally, CMS has instructed contractors to modify their software to deny claims related to surgical "never events" and track the occurrence of surgical errors. This, in conjunction with heightened government scrutiny to identify improper payments and the increased use of "data mining," makes it important for hospitals to bill "never events" correctly.

If a provider participating in the Medicare program fails to follow CMS' billing instructions, the provider increases its legal exposure. Under section 1833(e) of the Social Security Act (SSA), providers participating in federal health programs must be able to present sufficient medical documentation to support a claim for Medicare payment. Further, under section 1128B(a) of the Social Security Act and the False Claims Act, criminal and civil penalties may be imposed on providers that fail to accurately bill services and/or procedures to CMS.

Based on the information issued by CMS, it is imperative for hospitals to develop and implement policies regarding the reporting and accurate billing of surgical "never events." Hospitals may wish to incorporate the following concepts in their policies and procedures.

- ***When in doubt, review medical documentation.*** Hospitals should encourage their billing personnel to review medical documentation when uncertain about the services rendered.
- ***Always report surgical "never events."*** Hospitals receiving Medicare reimbursements are required to submit claims reporting surgical "never events." Failure to report surgical "never events" can result in Federal audit and or investigation.
- ***Develop a reporting process.*** Hospitals are encouraged to develop a reporting process when a surgical "never event" occurs. Questions to consider include, but are not limited to— How are surgical "never events" investigated within the hospital? How are surgical errors reported to the billing department? Is the compliance department involved in the process?
- ***Develop a culture for quality.*** The issuance of a National Coverage Determination regarding surgical "never events" reinforces CMS' commit to only pay for medically necessary services. Hospitals are encouraged to create a culture where the quality of medical services and safety of patients is not only important to physicians and other medical personnel, but also, to the hospital's administration (e.g. billing department, compliance department, health information management department, etc.).

Official Resources

- Medicare Program; Changes to the Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and Fiscal Year 2010 Rates; and Changes to the Long Term Care Hospital Prospective Payment System and Rate Years 2010 and 2009 Rates, 74 Fed. Reg. 165, 43790, 43792 (Aug. 27, 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." Medicare Transmittal 1819. 25 Sept. 2009.
- "Clarification of the Use of Modifiers When Billing 'Wrong Surgery on a Patient.'" MLN Matters Number: SE0927.
- "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." MLN Provider Inquiry Assistance: JA6405.
- CMS, Medicare Benefit Manual, CMS 100-02, Ch. 1, sec. 120, Services Related to and Required as a Result of Services Which Are Not Covered Under Medicare.
- CMS, Medicare Benefit Manual, CMS 100-02, Ch. 16, sec. 180, Services Related to and Required as a Result of Services Which Are Not Covered Under Medicare.
- CMS, National Coverage Determination Manual, CMS 100-03, Ch. 1 sec. 140.6-140.8.
- Social Security Act § 1833(e).
- Social Security Act § 1128B(a).