

Chapter 1

Section 37

Medical Errors

Issue Date: April 1, 2011

Authority: [32 CFR 199.4](#) and 10 USC Section 1079(a)(13)

Revision:

1.0 APPLICABILITY

10 United States Code (USC) Section 1079(a)(13) provides that TRICARE may only pay for medically necessary care. This statute has been implemented by the Code of Federal Regulations ([32 CFR 199.4](#)), which states that TRICARE will pay for “medically necessary services and supplies required in the diagnosis and treatment of illness or injury.” Therefore, TRICARE can cost-share only medically necessary supplies and services. Services that are not medically necessary are specifically excluded from TRICARE coverage.

2.0 POLICY

2.1 TRICARE will not cover a particular surgical or other invasive procedure to treat a particular medical condition when the provider performs:

- A wrong surgical or other invasive procedure on a patient;
- A surgical or other invasive procedure on the wrong body part; or
- A surgical or other invasive procedure on the wrong patient.

2.2 TRICARE will not cover hospitalizations and other services related to these medical errors. Services related to the medical error include:

- All services provided in the operating room when an error occurs are not covered.
- All providers in the operating room when the error occurs, who could bill individually for their services, are not eligible for payment.
- All related services provided during the same hospitalization in which the error occurred are not covered.

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

2.3 Following hospital discharge, any reasonable and necessary services are covered regardless of whether they are or are not related to the surgical error.

2.4 Beneficiary Liability

A TRICARE authorized provider cannot shift financial liability for the non-covered services related to surgical/medical errors to the beneficiary.

2.5 Inpatient Claims - Hospital Billing Procedures When a Medical Error Occurs

2.5.1 Hospitals are required to submit a no-pay claim (Type of Bill (TOB) 110) when an erroneous surgery/medical error as stated in this policy occurs.

2.5.2 If there are covered services/procedures provided during the same stay as the erroneous surgery/medical error, hospitals are then required to bill two claims - one claim with covered services or procedures unrelated to the erroneous surgery/medical error, and the other claim with the non-covered services/procedures as a no-pay claim. Hospitals are required to bill two claims when a surgical error is reported and a covered service is also being reported:

2.5.2.1 One claim with covered service(s)/procedure(s) unrelated to the erroneous surgery(ies) on a TOB 11X (with the exception of 110); and

2.5.2.2 The other claim with the non-covered service(s)/procedure(s) related to the erroneous surgery(ies) on a TOB 110 (no-pay claim).

Note: Both the covered and non-covered claim shall have a matching Statement Covers Period.

2.5.2.3 Additionally, the non-covered, no-pay claim TOB 110 must have one of the following diagnoses on the claim.

- Performance of wrong operation (procedure) on correct patient (existing code).
- Performance of operation (procedure) on patient not scheduled for surgery.
- Performance of correct operation (procedure) on wrong side/body part.

Note: The above diagnoses shall not be reported, as External Causes of Morbidity (V - Z codes).

2.5.2.4 In the event the hospital submits a TOB 11X claim with a diagnosis listed above, the claim is to be denied.

2.5.3 The onus is on the provider/hospital to bill correctly. The contractor is to ensure providers and hospitals understand the billing procedures outlined in this policy.

2.6 Outpatient, Ambulatory Surgery Centers (ASCs), and Individual Professional Provider Claims

2.6.1 Providers are required to append one of the following applicable Healthcare Common Procedure Coding System (HCPCS) modifiers to all lines related to the erroneous surgery(ies):

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

2.6.2 Claim lines submitted with one of the above HCPCS modifiers shall be denied as services that are not medically necessary. Claim lines for medically necessary services (i.e., without one of the above modifiers shall be allowed).

2.7 Within five business days of receiving a claim for a surgical error, contractors shall begin to review beneficiary history for related claims as appropriate (both claims already received and processed and those received subsequent to the notification of the surgical error).

2.7.1 In addition, contractors shall establish a mechanism to identify incoming claims that have the potential to be related.

2.7.2 When the contractor identifies such claims, the contractor shall take appropriate action to deny such claims and to recover any overpayments on claims already processed.

2.8 Appeals and Hearings

Medical error denials are appealable. The contractor is required to follow the requirements outlined in [32 CFR 199.10](#) and the TRICARE Operations Manual (TOM), [Chapter 13](#) related to the appeals and hearing process.

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