Indiana Medicaid Resolutions Manual

NAME: **6383 SURG PAY REDUCED AMT WHEN PRE-OP CARE ON DAY SURG**

ERROR TYPE: Contra Audit

HEADER/DETAIL: Detail

OVERRIDABLE: Y

ALLOW DENIAL: Y

DESCRIPTION:

This contra-indicated audit will set when the same provider who rendered preoperative care on the day of surgery bills for the surgical procedure.

CRITERIA:

When evaluation and management preoperative care services (see procedure codes within audit rules) are billed and surgery has been billed by the same provider on the same day (which has a value of 010 in the global surgery field in the Medicare Fee Schedule database), set this audit. If modifier 25 (separately identifiable E&M) or 57 (decision for surgery) is reported, the audit is overwritten and the claim pays. This is an NCCI audit.

DISPOSITION:

Note: EOB 9999 with a Do Not Post status is for internal system use only. This EOB is used to avoid potential system processing abends. This EOB is not posted on the RA and the disposition may be ignored.

Claim Type: 0 - All Claim Types **Member Plan:** ALL **Status:** Do Not Post

Location	Region	EOB	Disposition
22	00	9999	PAY

Claim Type: M - Professional Claims **Member Plan:** ALL **Status:** Post

Location	Region	EOB	Disposition
20	91	6383	SUSPEND
22	00	6383	DENY
22	30	6383	PAY

22	32	6383	PAY
22	33	6383	PAY
22	34	6383	PAY
22	61	6383	DENY
22	70	6383	PAY
22	72	6383	PAY
22	73	6383	PAY
22	74	6383	PAY

EOB: 6383 - REIMBURSEMENT REFLECTS THE DIFFERENCE BETWEEN INDIANA HEALTH COVERAGE PROGRAM'S ALLOWABLE FOR THE PROCEDURE BILLED AND THE AMOUNT PAID FOR THE COMPONENT(S).

ARC Code	ARC Description	Effective Date	End Date
B10	Allowed amount has been reduced because a component of the basic procedure/test was paid. The beneficiary is not liable for more than the charge limit for the basic procedure/test.	19950101	22991231

EOB: 9999 - PROCESSED PER POLICY.

ARC Code	ARC Description	Effective Date	End Date
97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Usage: Refer to the 835 Healthcare Policy Identification	19950101	22991231

Segment (loop 2110 Service Payment Information REF), if present.

METHOD OF CORRECTION:

Route the claim to the Medical Policy Specialist.

Medical Policy Specialist Instructions:

- Compare the claim to the suspense screen and correct any keying errors. If no keying errors:
- If the surgical procedure is billed with modifier 54 (surgical care only) by the same provider and the necessity of the visit was documented and justified, override the audit.
- Core claims will be returned to the provider for additional documentation needed to adjudicate the claim. Once the claim has been returned, it will be forced or denied and submitted for adjudication.
- Determine the reason for the preoperative visit paid in history.

a. If claim documents the care rendered is above routine care (e.g., active case management), override the audit.
b. If documentation is not present or does not justify care above routine care, calculate the amount due to the provider by subtracting the total amount paid for preoperative visits from the Medicaid allowable for the surgery. Price the surgery using this amount and EOB 6383.

   Effective 9/1/2009, as part of Change Order 1543-Paper Reduction, all Core regions with the exception of 21 and 61 will be set to deny. Regions 21 and 61 will remain as Core regions and go to the hold location (40) to be married up with attachments and/or claim notes. After the 45 days, claims will systematically deny.