NAME: **6382 PRE-OPERATIVE CARE ON DAY OF SURGERY**

ERROR TYPE: Contra Audit

HEADER/DETAIL: Detail

OVERRIDABLE: Y

ALLOW DENIAL: Y

DESCRIPTION:

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

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
22	00	6382	DENY
22	30	6382	PAY
22	32	6382	PAY

22	33	6382	PAY
22	34	6382	PAY
22	61	6382	DENY
22	70	6382	PAY
22	72	6382	PAY
22	73	6382	PAY
22	74	6382	PAY

EOB: 6382 - ROUTINE PREOPERATIVE MEDICAL VISITS PERFORMED ON THE DAY OF SURGERY ARE NOT SEPARATELY PAYABLE. DOCUMENTATION NOT PRESENT OR NOT SUFFICIENT TO JUSTIFY CARE WAS OF A NON-ROUTINE NATURE.

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 Segment (loop 2110 Service Payment Information REF), if present.	19950101	22991231

Remark Code	Remark Description	Effective Date	End Date
M144	Pre-/post-operative care payment is included in the allowance for the surgery/procedure.	19970101	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 Segment (loop 2110 Service Payment Information REF), if present.	19950101	22991231

METHOD OF CORRECTION:

Route the claim to the Medical Policy Specialist.

Medical Advisor Instructions:

- Compare the claim to the suspense screen and correct any keying errors. If no keying errors:
- If the claim documents the reason for the visit and it substantiates care above routine services (e.g. case management), override the audit.
- If the procedure paid was billed as surgical care only (modifier 54) by the same provider, and the necessity of the visit is documented and justified, override the audit.
- If the visit is related to the surgery, deny the service with EOB 6382.
- If no documentation provided on the claim or documentation does not justify the visit, deny the service with EOB 6382.
- CCF claims will be returned to the provider for additional documentation. Once the CCF is received, back from the provider, the claim will be forced or denied to adjudicate the claim appropriately.

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 45 days, the claims will systematically deny.

Indiana Medicaid Resolutions Manual