NAME: **6384 PRE-OPERATIVE CARE WITHIN 1 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 0-1 day prior to surgery.

CRITERIA:

When evaluation and management preoperative care services (see procedure codes within audit rules) are billed and payment has been made to the same provider for a surgical procedure with a value of 090 in the Global Surgery field in the Medicare Fee Schedule database for the same member within one (1) day prior to the date of surgery (including the day of surgery), set this audit. If modifier 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
04	00	9999	PAY

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

Location	Region	EOB	Disposition
22	00	6384	SUSPEND
22	30	6384	PAY

22	32	6384	PAY
22	33	6384	PAY
22	34	6384	PAY
22	61	6384	DENY
22	70	6384	PAY
22	72	6384	PAY
22	73	6384	PAY
22	74	6384	PAY

EOB: 6384 - ROUTINE PREOPERATIVE MEDICAL VISITS PERFORMED WITHIN ONE DAY PRIOR TO SURGERY ARE NOT SEPARATELY PAYABLE. DOCUMENTATION NOT PRESENT OR NOT SUFFICIENT TO JUSTIFY CARE WAS OF A NON-ROUTINE VISIT.

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 Policy Specialist Instructions:

- Compare claim to suspense screen and correct any keying errors. If no keying errors, check to see:
- If the claim documents the reasons for the visit and they substantiate 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. Review the modifiers billed to determine if the service is not part of the pre or post op care.
- If visit is related to the surgery, deny the service with EOB 6384.
- If no documentation is provided or documentation does not justify the visit, deny the service with EOB 6384.
- Core claims will be returned to the provider for additional documentation. Once the claim is received back from the provider, it 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 the 45 days the claims will systematically deny.