Indiana Medicaid Resolutions Manual

NAME: **6387 POST OP CARE WITHIN 10 DAYS OF SELECT 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 postoperative care within 0-10 days of the surgery.

CRITERIA:

When evaluation and management postoperative care services (see procedure codes within audit rules) are billed and payment has been made to the same provider for surgery with a value of 010 in the Global Surgery field in the Medicare Fee Schedule database for the same member within 0-10 days of the date of service, set this audit. If modifier 24 (Unrelated evaluation and management service) 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	6387	SUSPEND
22	30	6387	PAY

22	32	6387	PAY
22	33	6387	PAY
22	34	6387	PAY
22	61	6387	DENY
22	70	6387	PAY
22	72	6387	PAY
22	73	6387	PAY
22	74	6387	PAY

EOB: 6387 - POST OPERATIVE MEDICAL VISITS PERFORMED WITHIN 0-10 DAYS OF SURGERY ARE PAYABLE ONLY FOR A SURGICAL COMPLICATION AND IF DOCUMENTED AS MEDICALLY INDICATED. DOCUMENTATION NOT PRESENT OR DOES NOT JUSTIFY THE VISIT BILLED.

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

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	19950101	22991231

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.

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, check to see:
- If the claim documents the surgical complication necessitating the visit, override the audit. Surgical complications include, but are not limited to:

1. Post operative wound infection requiring specialized treatment.
2. Elevated temperature above 101 degrees F for two or more consecutive days.
3. Medical complications due to anesthesia, other than nausea/vomiting.
4. Nausea/vomiting that has persisted more than 24 hours.
5. Renal failure.
6. Comatose condition.
7. Cardiovascular complications.

- 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 visit is related to the original surgery, deny the service with EOB 6387.
- If no documentation is provided on or with the claim or documentation does not justify the visit, deny the service with EOB 6387.

Core claims will be returned to the provider for documentation needed to adjudicate the claim. Once the claim is received from the provider, the claim will be forced or denied to adjudicate the claim correctly.

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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.