Provider Billing Education: Duplicate Claim Submissions

In accordance with the Illinois Department of Healthcare and Family Services (HFS), Managed Care Organizations (MCO) have met to discuss opportunities to improve successful provider billing. This guidance focuses on "duplicate claim submission" criteria as defined by HFS.

Note- these rules may not apply for Provider Type 036 – Community Mental Health Providers.

Institutional Billing Guidelines:

HFS defines a duplicate claim as more than one claim submitted to a MCO using the same criteria when billed on UB-04 or 837 institutional claim formats.

Duplicating the following criteria will result in a claim rejection:

- Patient Medicaid ID
- Billing NPI/Provider Number
- Admit Thru Discharge Date, and
- Bill Type

HFS Guidance requires that providers submit only one claim using the above criteria. Claim lines should be used to bill for all services rendered. Failure to submit institutional claims according to these guidelines will result in payment of ONLY the first claim submitted. Claims billed using the same criteria will be rejected.

Institutional claim issues involving ER/OR and ancillary services are commonly rejected for failure to adhere to this guidance. The HFS guidance below describes the process that providers must follow when billing ER/OR and ancillary services on UB-04 claim forms:

- All ancillary services related to inpatient room & board stay must be billed as one encounter claim and not as separate encounter claims
- All laboratory, reports, drugs & other ancillaries related to an ER/OR visit are to be billed on one encounter claim and not as separate encounter claims

IF BILLED:	THEN:	RESOLUTION:
More than one claim: member ID, date of service, billed charges, provider NPI, claim form	Initial claim accepted then following claims denied Example 1: Claim 1 was billed for an ER with statement dates 01/04 thru 01/04 Example 1: Claim 2 was billed for lab related services with same statement dates 01/04 thru 01/04 Example 2: Claim 1 was billed for an ER with statement dates 01/04 thru 01/04 Example 2: Claim 2 was billed for an observe to inpatient stay with statement dates 01/04 thru 01/06	One claim must be submitted and all services provided must be itemized on individual claim lines Example 1: HFS requires these two claims to be combined, as all the services related to single episode of care (ER, lab, drugs, reports etc.) are to be reported as one claim. Example 2: HFS requires that when services subsequent to emergency department or observation services occur and the patient is then admitted to the hospital as an inpatient, only the emergency room charge or the observation service may be billed on the outpatient claim. It is up to the hospital to determine which outpatient service will provide greater reimbursement.

IF BILLED:	THEN:	RESOLUTION:
More than one claim different claim forms: member ID, date of service, billed charges, provider NPI, (different) claim forms	Institutional and Professional claims accepted if no further billing issues. Example 1: Claim 1 was a UB claim billed for an ER visit with statement dates 01/04 thru 01/04 Example 1: Claim 2 was a professional claim from a radiologist services with same statement dates 01/04 thru 01/04	A UB-04 claim submitted for ER can be submitted on the same day as the professional charges billed on the HCFA form.

Professional and Ancillary Billing Guidelines:

HFS and the MCOs have conducted duplicate claim investigations for professional and ancillary services billed on the CMS-1500 or 837 professional claim formats.

Please refer to the link below outlining the practitioner fee schedule key as defined by HFS: https://www.illinois.gov/hfs/MedicalProviders/MedicaidReimbursement/FeeSchedule/Pages/2016FeeSchedule.aspx

HFS guidance included in the practitioner fee schedule key must be followed when using the practitioner fee schedule. Failure to submit professional and ancillary claims using this guidance are subject to rejection(s).

Frequent professional and ancillary claim issues involving DME, radiology, laboratory reports, injections, and therapy services are common. Below is direct guidance from HFS that needs to be followed when billing DME, radiology, laboratory reports, injections, and therapy services on CMS-1500 or 837 professional claim formats:

- All DME and radiology claims should be billed as unit quantity and NOT on a separate service section. All applicable modifiers are to be reported on the same service section (Reference A-224 Radiology Services: https://www.illinois.gov/hfs/SiteCollectionDocuments/a200.pdf)
- Injections, labs reports, and tests must be billed with specific procedure code on one service section
- Injections, labs reports, and tests must be billed with an unlisted procedure code for quantities greater than one in the next service section. Then, list the total number and name of additional tests in the description field (NTE segment) (Reference L-210.21 Independent Laboratory Services: https://www.illinois.gov/hfs/SiteCollectionDocuments/l200.pdf).
- Therapy must be billed with the units of time covered by the therapy session. Fifteen-minute intervals equal one (1) unit. A maximum of four (4) units are allowed per date of service for therapy. A maximum of eight (8) units are allowed for children's evaluations.
- Therapy must be billed with one service section for each item (PT, OT or ST) or service provided to the patient along with the right modifiers GP, GO or GN, if billing multiples.
- Modifiers 25 and 59 should not be billed multiple times for the same service rendered multiple times on the same date of service. Modifiers should be reported appropriately for and be used to improve reporting accuracy.
- Pricing modifiers are used with the procedures listed in the fee schedule to affect the procedure code's fee or cause a claim to pend for review. For more information, please refer to the HFS website and search for modifiers at http://www2.illinois.gov/hfs/. Duplicate pricing modifiers should not be submitted multiple times on the same claim detail line.

Submitted Corrected/Voided Claims

NOTE: If the below guidance is not followed for a corrected or voided claim submission, the claim WILL be denied as a duplicate.

Institutional claims:

If you are submitting a void/replacement **paper** UB-04 claim, please use appropriate bill type ending in either "XX7" or "XX8"

- XX7 is submitting a replacement/corrected claim.
- XX8 if submitting a void/cancel of a previous claim.
- The original claim number should be submitted in field 64 of the paper claim.
  - If at all possible, include the original claim number on the form. This is NOT required, however will ensure greater speed and accuracy when reprocessing.

UB-04 Example

Box 64: Original claim number

If you are submitting a void/replacement claim UB04 electronically, please provide this information:

- Loop 2300
- CLM05-3 (Claim Frequency Type Code) must be entered as 7 for Replacement or 8 for void.
- Include REF segment with the original claim number from the remittance advice, REF01 = "F8", REF02 = Original claim number

Note, resubmission of a corrected claim must include the entire episode of care, not just a single claim line. Upon resubmission, the original claim will be recouped, and the corrected XX7 will replace the initial episode.

ACTION NEEDED	BILL TYPE REQUIRED
Adjustment of the original claim submitted is needed due to corrections made. The new claim will be considered as a replacement of a previously processed claim.	XX7: Correction/Replacement of Prior Claim
A previously submitted claim needs to be eliminated in its entirety. This would be necessary if the claim submitted was completely erroneous and was not appropriate for submission to the Plan for any reason.	XX8: Void/Cancel of Prior Claim

Professional Claims

If you are submitting a void/replacement **paper** CMS 1500 claim, please complete box 22.

- For replacement or corrected claim enter resubmission code 7 in the left side of item 22 and enter the original claim number of the claim you are replacing in the right side of item 22.
- If submitting a void/cancel claim, enter resubmission code 8 in the left side of item 22 and enter the original claim number of the paid claim you are voiding/canceling in the right side of item 22.

CMS-1500 Example *(please use red form for official submission)*

Box 22: Original claim # of denied claim. Note: Not to be used if original claim was rejected

Box 22: Use 7 for corrected

If you are submitting a void/replacement HCFA 1500 claim **electronically**, please provide this information:

- Loop 2300
- CLM05-3 (Claim Frequency Type Code) must be entered as 7 for Replacement or 8 for void.
- Include REF segment with the original claim number from the remittance advice, REF01 = "F8", REF02 = Original claim number.

ACTION NEEDED	REQUIRED SUBMISSION CODE
Adjustment of the original claim submitted is needed due to corrections made. The new claim will be considered as a replacement of a previously processed claim.	7: Correction/Replacement of Prior Claim
A previously submitted claim needs to be eliminated in its entirety. This would be necessary if the claim submitted was completely erroneous and was not appropriate for submission to the Plan for any reason.	8: Void/Cancel of Prior Claim

Submission Timelines

Initial Claim for Service:

- 180 calendar days from date of service rendered

Requests for Claim Reconsideration or Submission of Corrected Claim:

- 45 calendar days from the date of the Explanation of Payment (EOP)

Mailing Address for Paper Claims Submission:

CountyCare Health Plan
P.O. Box 211592
Eagan, MN 55121-2892

Payor ID for Electronic Claims Submission:

PAYOR ID 06541