DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

MLN Matters®

Information for Medicare Fee-For-Service Health Care Professionals

News Flash –

REVISED products from the Medicare Learning Network® (MLN)

- "The Basics of Medicare Enrollment for Physicians and Other Part B Suppliers," Fact Sheet, ICN 903768, Downloadable only.

MLN Matters® Number: MM8121

Related Change Request (CR) #: CR 8121

Related CR Release Date: March 29, 2013

Effective Date: April 29, 2013

Related CR Transmittal #: R2678CP

Implementation Date: April 29, 2013

Clarification of Detection of Duplicate Claims Section of the CMS Internet Only Manual

Provider Types Affected

This MLN Matters® Article is intended for physicians, providers, and suppliers submitting claims to Medicare contractors (carriers, Fiscal Intermediaries (FIs), A/B Medicare Administrative Contractors (A/B MACs), Durable Medical Equipment Medicare Administrative Contractors (DME MACs), and/or Regional Home Health Intermediaries (RHHIs)) for services provided to Medicare beneficiaries.

Provider Action Needed

STOP – Impact to You

The purpose of this Change Request (CR) is for clarification only and does not constitute any change in Medicare policy. The Centers for Medicare & Medicaid Services (CMS) is alerting providers to the

update of the Medicare Internet-Only Manual (IOM), Chapter 1, Section 120: "Detection of Duplicate Claims."

CAUTION – What You Need to Know

Change Request (CR) 8121, from which this article is taken, alerts providers that the claims processing systems contain edits which identify duplicate claims and suspect duplicate claims. All exact duplicate claims or claim lines are auto-denied or rejected (absent appropriate modifiers). Suspect duplicate claims and claim lines are suspended and reviewed by the Medicare contractors to make a determination to pay or deny the claim or claim line.

GO – What You Need to Do

Please be aware that Medicare contractors examine and compare to the prior bill any bill that is identified as a suspect duplicate. If the services (revenue or HCPCS codes) on a claim duplicate the services for the other, contractors will check the diagnosis. If the diagnosis codes are duplicates, contractors will request an explanation before making payment. The official instruction for CR8121 spells out what your Medicare contractor looks for when analyzing the history of paid and pending claims, duplicate claims and the criteria for detecting suspect duplicate claims.

Background

Some claims that appear to be duplicates are actually claims or claim lines that contain an item or service, or multiple instances of an item or service, for which Medicare payment may be made. Correct coding rules applicable to all billers of health care claims encourage the appropriate use of condition codes or modifiers to identify claims that may appear to be duplicates, but are in fact, not.

For example, there are some Healthcare Common Procedure Coding System (HCPCS) modifiers that are appropriate to be appended to some services and can indicate that a claim line is not a duplicate of a previous line on the claim. Level I modifiers would typically be used by a biller to indicate that a potential duplicate claim or claim line is not, in fact, a duplicate. Level II modifiers may also be used. The Level II modifiers “RT” and “LT,” for example, indicate that a service was performed on the right and left side of the body, respectively.

However, not every HCPCS code has an appropriate modifier to indicate that a claim line is not a duplicate. In that case, the claims and claim lines are reviewed by Medicare Contactors’ local software modules for a determination, or they suspend for contractor review.

Key Points of CR8121

Exact Duplicates

A. Submission of Institutional Claims

Claims or claim lines that have been determined an exact duplicate are rejected and do not have appeal rights. An exact duplicate for institutional claims is a claim or claim line that exactly matches another claim or claim line with respect to the following elements:

- Health Insurance Claim (HIC) number;
- Type of Bill;
- Provider Identification Number;
- From Date of Service;
- Through Date of Service;
- Total Charges (on the line or on the bill); and
- HCPCS, CPT-4, or Procedure Code modifiers.

Whenever any of the following claim situations occur, your Medicare contractor develops procedures to prevent duplicate payment of claims. This includes, but is not limited to:

- Outpatient payment is claimed where the date of service is totally within inpatient dates of service at the same or another provider.
- Outpatient bill is submitted for services on the day of an inpatient admission or the day before the day of admission to the same hospital.
- Outpatient bill overlaps an inpatient admission period.
- Outpatient bill for services matches another outpatient bill with a service date for the same revenue code at the same provider or under a different provider number.

B. Claims Submitted by Physicians, Practitioners, and other Suppliers (except DMEPOS Suppliers)

Claims or claim lines that have been determined an exact duplicate are denied. Such denials may be appealed. An exact duplicate for physician and other supplier claims submitted to a MAC or carrier is a claim or claim line that exactly matches another claim or claim line with respect to the following elements:

- HIC Number;
- Provider Number;
- From Date of Service;
- Through Date of Service;
- Type of Service;
- Procedure Code;
- Place of Service; and

- Billed Amount.

C. Claims Submitted by DMEPOS Suppliers

Claims or claim lines that have been determined an exact duplicate are denied. Such denials may not be appealed. An exact duplicate for DMEPOS Supplier claims submitted to a DME MAC is a claim or claim line that exactly matches another claim or claim line with respect to the following elements:

- HIC Number;
- From Date of Service;
- Through Date of Service;
- Place of service;
- HCPCS;
- Type of Service;
- Billed Amount; and
- Supplier.

Suspect Duplicates

Suspect duplicates are claims or claim lines that contain closely aligned elements and require that the claim be reviewed.

A. Criteria for Detecting Suspect Duplicates on Institutional Claims

A "suspect duplicate" claim is a claim being processed which, when compared to Medicare's history or pending files, begins with these characteristics:

- Match on the beneficiary information;
- Match on provider identification; and
- Same date of service or overlapping dates of service.

B. Suspect Duplicate Claims Submitted by Physicians and other Suppliers (including DMEPOS Claims)

The criteria for identifying suspect duplicate claims submitted by physicians and other suppliers vary according to the type of billing entity, type of item or service being billed, and other relevant criteria. The denial of claim as a duplicate of another claim may be appealed when the denial is based on criteria other than those specified above for exact duplication.

Additional Information

You can find the official instruction, CR8121, issued to your FI, carrier, A/B MAC, RHHI, or DME MAC by visiting http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2678CP.pdf on the CMS website.

If you have any questions, please contact your FI, carrier, A/B MAC, RHHI, or DME MAC at their toll-free number, which may be found at http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html on the CMS website.