CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 2678	**Date: March 29, 2013**
	Change Request 8121

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

I. SUMMARY OF CHANGES: The purpose of this CR is to clarify pub 100-04, chapter 1, section 120: "Detection of Duplicate Claims" of the Medicare Internet-Only Manual (IOM).

EFFECTIVE DATE: April 29, 2013
IMPLEMENTATION DATE: April 29, 2013

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	1/120/Duplicate Claims
N	1/120.1/Overview
N	1/120.2/Exact Duplicates
N	1/120.3/Suspect Duplicates

III. FUNDING:
For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs) and/or Carriers:
No additional funding will be provided by CMS; Contractors activities are to be carried out with their operating budgets

For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC statement of Work. The contractor is not obliged to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:

Business Requirements
Manual Instruction

**Unless otherwise specified, the effective date is the date of service.*

Attachment - Business Requirements

Pub. 100-04	Transmittal: 2678	Date: March 29, 2013	Change Request: 8121

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

EFFECTIVE DATE: April 29, 2013
IMPLEMENTATION DATE: April 29, 2013

I. GENERAL INFORMATION

A. Background: The purpose of this change request (CR) is to clarify pub 100-04, chapter 1, section 120: "Detection of Duplicate Claims" of the Medicare Internet-Only Manual (IOM).This CR does not constitute any new work and is for clarification purposes only.

B. Policy: 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 claims administration contractors to make a determination to pay or deny the claim or claim line.

II. BUSINESS REQUIREMENTS TABLE

Use "Shall" to denote a mandatory requirement.

Number	Requirement	Responsibility										
		A/B MAC		DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				Other
		Part A	Part B					FISS	MCS	VMS	CWF	
8121.1	Contractors shall be aware of the changes to chapter one (1), section 120, in 100-04: Detection of Duplicate claims. These changes are for clarification purposes only.	X	X	X	X	X	X					

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility						
		A/B MAC		DME MAC	FI	CARRIER	RHHI	Other
		Part A	Part B					

Number	Requirement	Responsibility						
		A/B MAC		DME MAC	FI	CARRIER	RHHI	Other
		Part A	Part B					
8121.2	MLN Article : A provider education article related to this instruction will be available at http://www.cms.hhs.gov/MLNMattersArticles/ shortly after the CR is released. You will receive notification of the article release via the established "MLN Matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web sites and include information about it in a listserv message within one week of the availability of the provider education article. In addition, the provider education article shall be included in the contractor's next regularly scheduled bulletin. Contractors are free to supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.							

IV. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements:
Use "Should" to denote a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

Section B: All other recommendations and supporting information:

V. CONTACTS

Pre-Implementation Contact(s): Mark Baldwin, 410-786-8139 or mark.baldwin@cms.hhs.gov (Part B contact) , Diana Motsiopoulos, 410-786-3379 or diana.motsiopoulos@cms.hhs.gov (DME Contact) , Cindy Pitts, 410-786-2222 or cindy.pitts@cms.hhs.gov (Part A Contact)

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR) or Contractor Manager, as applicable.

VI. FUNDING

Section A: For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs), and/or Carriers:
No additional funding will be provided by CMS; Contractors activities are to be carried out with their operating budgets

Section B: For Medicare Administrative Contractors (MACs):

The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS do not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

120 - Duplicate Claims

(*Rev.2678, Issued: 03-29-13, Effective: 04-29-13***.** Implementation: 04-29-13)

120.1 Overview

(Rev.2678, Issued: 03-29-13, Effective: 04-29-13. Implementation: 04-29-13)

The claims processing systems contain edits which identify exact 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 claims administration contractors to make a determination to pay or deny the claim or claim line.

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, in fact, are not.

For example, there are some 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 associated 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.

120.2 Exact Duplicates

(Rev.2678, Issued: 03-29-13, Effective: 04-29-13. Implementation: 04-29-13)

Exact duplicates are controlled by the claims processing system through "hard coded" edits, and may not be user-controlled. In addition, Medicare contractors cannot override or bypass exact duplicate edits.

A. Submission of Institutional Claims

Claims or claim lines that have been determined to be 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:

- *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.*

Additional Instructions for Institutional Claims:

Whenever any of the following claim situations occur, the MAC 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. Do not consider outpatient services provided on the day of discharge within the inpatient dates of service.*
- *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.*

1. History File - Paid Claims

The MACs and legacy claims administration contractors must maintain a history file containing information about each claim processed. The file may consist of the claim or information from it. It must contain the following minimum information:

- *Beneficiary HICN;*
- *Beneficiary name information;*
- *Provider identification (name or number); and*
- *Billing period from the claim.*

Claims or claims information in the history file may be transferred to inactive files. However, the MAC must have the facility to recall such claims or information if a claim for the beneficiary involving the same time period is received.

2. History File - Pending Claims

Contractors must have controls to prevent a duplicate claim from being paid while two claims are in the process within the system at the same time. This may be accomplished through a special check of in-process claims or in the history file for paid claims. The file should contain the same minimum information indicated in the subsections below. The check should be performed prior to sending the claim to CWF.

3. Analysis of Patterns of Duplicate Claims

The contractors shall establish a system for continuing analysis of duplicate claims. This includes the systematic evaluation of returned "Medicare Summary Notices" from beneficiaries and communications from providers indicating a duplicate payment has been made, as well as returned checks from any payee.

The contractor's system should provide for analyzing duplicate claim receipts to determine whether certain providers are responsible for duplicates and, if so, identify those providers. The contractor should educate such providers to reduce the number of duplicates they submit. Should those providers continue to submit duplicate claims, the MAC should initiate program integrity action.

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

Claims or claim lines that have been determined to be exact duplicates of another claim or claim line are denied. However, 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 to be exact duplicates of another claim or claim line 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 code;*
- *Type of Service;*
- *Billed Amount;*
- *Supplier*

120.3 Suspect Duplicates
(Rev.2678, Issued: 03-29-13, Effective: 04-29-13. Implementation: 04-29-13)

Suspect duplicates are claims or claim lines that contain closely-aligned elements sufficient to suggest that duplication may be present and, as such, require that the suspect claim be reviewed. Suspect duplicate edits can be hard coded in the system or local edits set up by Medicare contractors.

A. Criteria for Detecting Suspect Duplicates for Institutional Claims

A "suspect duplicate" claim is a claim being processed which, when compared to the history or pending file, begins with these characteristics:

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

The 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 should check the diagnosis. If the diagnosis codes are duplicates, obtain an explanation from the provider before making payment.

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 are not published and 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.

A/B MACs, Part B legacy contractors, and DME MACs must add an informational indicator to the Common Working File (CWF) transaction record when, as a result of a contractor audit/edit or CWF reject, the contractor examines what appears to be a duplicate item or service and approves it for payment.