CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 3262	**Date: May 15, 2015**
	Change Request 9079

SUBJECT: Manual Update to Pub. 100-04, Chapter 1, to include Claims Submitted by Multiple DMEPOS Suppliers

I. SUMMARY OF CHANGES: The purpose of this change request (CR) is to revise the manual subsection, 120.2 “Exact Duplicates”, in Pub.100-04, Chapter 1.

EFFECTIVE DATE: July 1, 2015
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: July 6, 2015

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	1/120/2 Exact Duplicates

III. FUNDING:
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 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.

IV. ATTACHMENTS:

Business Requirements
Manual Instruction

Attachment - Business Requirements

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I. GENERAL INFORMATION

A. Background: A recent clarification of Centers for Medicare & Medicaid Services (CMS) claims processing policy requires a revision to the Internet Only Manual (IOM) Publication 100-04, Chapter 1. Therefore the purpose of this CR is to revise manual subsection, 120.2 D "Claims Submitted by Multiple DMEPOS Suppliers", of100-04, Medicare Claims Processing Manual, Chapter 1.

B. Policy: Effective July 1, 2015, when a second supplier submits a diabetic testing supply claim for a span date already approved for the same beneficiary for a different supplier, the DME MAC shall deny the second supplier's claim as a duplicate claim, rather than a suspect duplicate claim.

II. BUSINESS REQUIREMENTS TABLE

"Shall" denotes a mandatory requirement, and "should" denotes an optional requirement.

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
9079.1	Contractors shall be in compliance with the updates to CMS Internet Only Manual (IOM) Publication 100-04, Chapter 1-General Billing Requirements, section 120.2 D				X					

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
9079.2	MLN Article: A provider education article related to this instruction will be available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-				X	

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
	Network-MLN/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 5 business days after receipt of the notification from CMS announcing the availability of the 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:

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:
	N/A

Section B: All other recommendations and supporting information: N/A

V. CONTACTS

Pre-Implementation Contact(s): Bobbett Plummer, 410-786-3321 or bobbett.plummer@cms.hhs.gov

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR).

VI. FUNDING

Section A: 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 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.

ATTACHMENTS: 0

120.2 - Exact Duplicates

(Rev.3262, Issued: 05-15-15, Effective: 07-01-15, Implementation: 07-06-15)

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

D. Claims Submitted by Multiple DMEPOS Suppliers

When a second DMEPOS supplier or multiple DMEPOS suppliers submit a claim during a span date already approved for the same beneficiary for a different DMEPOS supplier, the DME MAC shall deny the second or subsequent DMEPOS supplier's claim as a duplicate not a suspect duplicate when the following conditions are met:

- *Same Beneficiary Health Insurance Claim Number (HICN)*
- *Overlapping span Date of Service (DOS) (From DOS and Through DOS)*
- *Same Healthcare Common Procedure Coding System (HCPCS) Code,*
- *Same Type of Service on the incoming claim matches a previously approved claim in history, and*
- *The item is a diabetic testing supply*

- ***Items Subject to Duplicate Editing***
    1. *Diabetic Testing Supplies*