Duplicate Encounter Avoidance Guidelines

MCO Encounter Improvement Initiative

Meridian Health Plan

meridian

Provider Billing Education: Duplicate Claim Submissions

Institutional Billing Guidelines

HFS considers 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 UB-04/837I claim rejection:
  - Patient Medicaid ID
  - Billing NPI/Provider Number
  - Admit Through Discharge Date, and
  - Bill Type

- HFS guidance to MCOs requires that providers submit only one claim using the above criteria. Failure to submit correctly will result in payment of ONLY the first claim submitted. Additional claims billed using the same criteria will be rejected.

Provider Billing Education: Duplicate Claim Submissions

Institutional Billing Guidelines

Institutional claims for Emergency Room and/or outpatient observation services and related ancillary services may be rejected for failure to adhere to the HFS guidance below. Hospitals must follow this guidance when billing ER/OBV and ancillary services on UB-04/837I claim forms:

- All ancillary services related to an inpatient hospital stay must be billed together with room and board charges on a single inpatient claim.
- All outpatient laboratory, radiology, drugs, and other hospital ancillary services provided during an ER/OR visit must be billed on one claim and not as separate claims.
- These services are billed on the inpatient claim for a subsequent admission if the date of admission is the same as the date the patient began the episode of care in the ER. These services are billed together with the ER/OBV charge on a separate outpatient claim if the patient began the episode of care in the ER on a date other than the date of the subsequent admission.

Provider Billing Education: Duplicate Claim Submissions

Institutional Billing Guidelines

Example 1:

- Scenario: An institutional provider (Billing NPI 999999999) treats a member twice on the same date of service (3/1/2017) for the same bill type 131 and submits two separate claims on a UB-04 form
- Outcome: The first claim submitted will be accepted, however the second claim will be denied
- Resolution: One outpatient claim must be submitted, and all services provided must be itemized on individual service lines

Provider Billing Education: Duplicate Claim Submissions

Different Claim Forms Billing Guidelines

Example 2:

- Scenario: An institutional provider (Billing NPI 999999999) treats a member twice on the same date of service 3/1/2017. One claim is under bill type 131 with revenue code 0450 on UB-04 form. One claim is billed for professional services on HCFA CMS-1500 form.
- Outcome: Institutional and Professional claims are accepted if no billing issues are found.
- Resolution: A UB-04 claim submitted for ER services can be submitted for the same date of service under the same billing NPI as the HCFA CMS-1500 claim.

Provider Billing Education: Duplicate Claim Submissions

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/SiteCollectionDocuments/4.22.16PractitionerFeeScheduleKey.pdf.

- 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).

Provider Billing Education: Duplicate Claim Submissions

Professional and Ancillary Billing Guidelines

- Frequent professional and ancillary claim issues involve DME, radiology, laboratory reports, injections, and therapy services.
  - 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 claim detail line
  - 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 procedure code description field SV101.
    - (Reference L-210.21 Independent Laboratory Services: https://www.illinois.gov/hfs/SiteCollectionDocuments/l200.pdf).

Provider Billing Education: Duplicate Claim Submissions

Professional and Ancillary Billing Guidelines

- Therapy must be billed with the units of time covered by the therapy session.
  - Fifteen-minute intervals equal one (1) unit.
- Therapy must be billed with one service section for each item
  - PT, OT, or ST, or service provided to the patient
  - Include correct modifiers GP, GO, or GN if billing multiples
  - Multiple types of therapy can be performed on the same date of service
- 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.

Provider Billing Education: Duplicate Claim Submissions

Void/Replacement Claims

- If you are submitting a void/replacement **paper** UB-04 claim, please use appropriate bill type of 137 or 138. 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.

Provider Billing Education: Duplicate Claim Submissions

Void/Replacement Claims

- Action: 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.
  - Bill Type Required: xx7 - Replacement of Prior Claim
- Action: A previously submitted claim needs to be completely 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.
  - Bill Type Required: xx8 - Void/Cancel of Prior Claim

Provider Billing Education: Duplicate Claim Submissions

Void/Replacement 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. 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.

Provider Billing Education: Duplicate Claim Submissions

Void/Replacement Claims

- Action: 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.
  - Required Submission Code: 7 - Replacement of Prior Claim

- Action: A previously submitted claim needs to be completely 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.
  - Required Submission Code: 8 - Void/Cancel of Prior Claim

Reference Material

- HFS Practitioner Fee Schedule Key: https://www.illinois.gov/hfs/SiteCollectionDocuments/4.22.16PractitionerFeeScheduleKey.pdf
- HFS Rendering Medical Services Handbook: https://www.illinois.gov/hfs/SiteCollectionDocuments/a200.pdf
- HFS Laboratory Services Handbook: https://www.illinois.gov/hfs/SiteCollectionDocuments/l200.pdf
- Provider Billing Education: Duplicate Claim Submissions http://iamhp.net/resources/Pictures/D01%20Guidelines%20-%20IAMHP%20Provider%20Memo.pdf