



Provider Memorandum

Provider Billing Education: Duplicate Claim Submissions

In partnership with the Illinois Department of Healthcare and Family Services (HFS), Managed Care Organizations (MCOs) have met to discuss opportunities to improve successful provider billing. The following guidance focuses on “duplicate claim submission” criteria as defined by HFS when accepting encounter data from MCOs, and is created to assist providers in submitting Medicaid managed care claims that do not reject by MCOs as duplicates.

NOTE: Community Mental Health Centers (CMHCs) must follow additional guidance to prevent 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 837institutional claim formats.

Duplicating the following criteria will result in a UB-04/837Iclaim 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. 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. Additional claims billed using the same criteria will be rejected.

Institutional claims for Emergency Room and/or outpatient observation services and related ancillary services are 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.

Scenario	Outcome	Resolution	Example
<p>More than one UB-04/837I claim on which the following criteria are the same:</p> <ul style="list-style-type: none"> Member ID Date of Service Provider NPI Bill Type 	Initial claim is accepted, and the following claim is denied	One outpatient claim must be submitted, and all services provided must be itemized on individual service lines	<p>Claim 1 (bill type 131) was billed for an ER visit with statement dates 01/04 through 01/04.</p> <p>Claim 2 (bill type 131) was billed for lab service with the same statement dates 01/04 through 01/04.</p> <p>Outcome: Claim 1 accepted, Claim 2 rejected</p> <p>Resolution: HFS requires these 2 claims to be combined as all the services (ER, lab, drugs, radiology, etc.) related to a single episode of care are to be reported on one claim.</p>
Scenario	Outcome	Resolution	Example
<p>More than one claim, but different claim forms with the same:</p> <ul style="list-style-type: none"> member ID Date of Service Provider NPI 	Institutional and Professional claims accepted if no further billing issues.	A UB-04/837I claim submitted for ER services can be submitted on the same day as the professional charges billed on the HCFA CMS-1500/837P.	<p>Claim 1 was a UB-04/837I claim billed for an ER visit with statement dates 01/04 through 01/04.</p> <p>Claim 2 was a professional claim from a radiologist for services with same statement dates 01/04 through 01/04.</p>

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).

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.

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.

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: Replacement of Prior Claim
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.	xx8: Void/Cancel of Prior Claim

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.

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: Replacement of Prior Claim
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.	8: Void/Cancel of Prior Claim