I. SCOPE:

This policy describes the system requirements and procedures to ensure that duplicate claim submissions are detected and processed correctly.

II. POLICY:

The Information System will edit any claim that meets criteria indicating that the submitted services are a possible or exact duplicate of another claim previously submitted, or where the same service was provided on the same date of service as a claim submitted previously. This will ensure that all claims that have a potential to be a duplicate are detected on a prepayment basis and processed accurately.

III. PROCEDURE:

The criteria for each review established in Information System and the procedures that are followed for each is described below:

A. Possible Duplicate - Information System will edit any claim which has the same date of service, same provider specialty, same procedure code (up to the full nine digits - 5 digits for the CPT/HCPC code and up to 4 digits for modifiers) and the same member number as another claim in the system on a per detail line basis. This edit applies some artificial intelligence (a software titled AdjudiPro or ClaimCheck) in addition to manual processes.

1. AdjudiPro will automatically clear any current claim pending to this review when the similar claim in claim history has been denied.

2. AdjudiPro will automatically clear any claim submitted by a Durable Medical Equipment vendor or pharmacy provider as there are specific edits designed to address issues relevant to providers of this types.

3. All remaining claim types are sent to a manual review where the processor will check claim history for the member involved to ensure that the services submitted are not a duplicate to the claim pending on this edit. This review works in concert with the same day same service edit to detect any variation in procedure codes from one submission to the next.

B. Exact Duplicate - Information System will automatically deny any claim that has a previously issued payment if the claim submitted contains the same provider number, member number, claimed amount, date of service, procedure code, and units. The Information System will send to a manual review any claim that has previously issued a $0
payment if the claim submitted contains the same provider number, member number
claimed amount, date of service, procedure code, and units.

1. The processor will review the claim pending to identify if there are any data
entry errors and if no errors are detected the claim review will be cleared for
payment.

2. If the original claim, in member claims history, was denied due to lack of
backup documentation and no documentation is submitted (example COB
claim missing a payment voucher/EOMB from the primary carrier), the
claim will be denied for the same reason code utilized on the original claim
denial.

C. Same Day/Same Service - Information System will edit any claim which contains the same
physician (or physicians of the same specialty in the same group practice, by cross-
matching the provider number, Federal Tax ID number or subspecialty indicator) that
submit(s) more than one evaluation and management (E/M) service for the same member
on the same day of service.

1. A set of logic is established for newborn services provided in a hospital
setting, psychiatric services to detect therapy vs. consultation, preventive
medicine vs. E/M services, initial vs. subsequent hospital services, initial
nursing facility care, and general E/M services, to detect duplicate
submissions based on the nature of that specific service and process
accurately.