Indiana Medicaid Resolutions Manual

NAME: **5000 POSSIBLE DUPLICATE**

ERROR TYPE: Form Audit

HEADER/DETAIL: Detail

OVERRIDABLE: Y

ALLOW DENIAL: Y

DESCRIPTION:

Set this audit when the claim being processed is a possible duplicate of history claims or another claim being processed in the same cycle.

CRITERIA:

When another claim is found with the following criteria (compare current claim with paid history claims and other claims processing in the same cycle), set this audit with EOB 5000.

Medical and Medical Crossover Claims:

Bypass condition: When the current and history detail has procedure code T1015 (FQHC/RHC claims), bypass this audit. FQHC/RHC claims will only set AU 5001 where applicable.
The current claim detail will be compared to the history claim detail fields as follows:

- Same member number
- Same or different rendering provider number (when a CRNA bills with their individual rendering NPI, modifier QX and QZ are not to be appended to the code as this allows for a double reduction when billed by provider specialty of 094 and the modifier reduction).
- Same or overlapping dates of service
- Same procedure code
- All modifiers do not match history
- Same NDC code (this is only applicable to procedure codes configured within the audit rules that are required configured NDC) AND neither detail (on the same claim only) has a KQ or KP modifier.
- And additional criteria exists. See AU 5000 Flowcharts.xlsx for more information on the criteria for setting AU 5000 for Physician and CT M claims.

LTC Claims:

The current claim detail will be compared to the history claim detail fields as follows:

- Same member number
- Same or different billing provider number

  - If billing provider number is different and the history claim is CT I, L or A and the dates of service do NOT overlap by 1 day (i.e. same day transfers), set AU 5000.

- Overlapping dates of service
- Same or different revenue code

  - For different revenue codes, if both the current and history claim revenue codes are in revenue group 59, set AU 5000.

Home Health Claims:

The current claim detail will be compared to the history claim detail fields as follows:

- Same member number
- Same billing provider number
- Same date of service
- Different revenue codes
- Same procedure codes
- At least one same modifier

Outpatient/Outpatient Crossover Claims:

The current claim detail will be compared to the history claim detail fields as follows:

- Same member number
- Same billing provider number
- Same first date of service
- Same revenue code
- Same NDC code (this is only applicable to procedure codes configured within the audit rules that are required configured NDC)
- All modifiers do Not match

- Additional criteria exists. See AU 5000 Flowcharts.xlsx for more information on the criteria for setting AU 5000 for Outpatient/Outpatient Crossover claims.

Dental Claims:

The current claim detail will be compared to the history claim detail fields as follows:

- Same member number
- Different rendering provider number
- Same From date of service
- Same procedure code (but not a procedure code in Group 142)
- Same tooth number
- Same area of the oral cavity (AOTOC)

Certain dental procedures bypass dental duplicate audits (see procedure codes within audit rules).

DISPOSITION:

Note: EOB 9999 with a Do Not Post status is for internal system use only. This EOB is used to avoid potential system processing abends. This EOB is not posted on the RA and the disposition may be ignored.

Claim Type: 0 - All Claim Types **Member Plan:** ALL **Status:** Do Not Post

Location	Region	EOB	Disposition
20	00	9999	PAY

Claim Type: B - Professional Xover Claims **Member Plan:** ALL **Status:** Post

Location	Region	EOB	Disposition
20	00	5000	SUSPEND
20	30	5000	PAY
20	32	5000	PAY
20	33	5000	PAY
20	34	5000	PAY
20	70	5000	PAY
20	72	5000	PAY
20	73	5000	PAY
20	74	5000	PAY
20	91	5000	SUSPEND

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Claim Type: C - Outpatient Xover Claims **Member Plan:** ALL **Status:** Post

Location	Region	EOB	Disposition
20	00	5000	SUSPEND
20	30	5000	PAY
20	32	5000	PAY
20	33	5000	PAY
20	34	5000	PAY
20	70	5000	PAY
20	72	5000	PAY
20	73	5000	PAY
20	74	5000	PAY
20	91	5000	SUSPEND

Claim Type: D - Dental Claims **Member Plan:** ALL **Status:** Post

Location	Region	EOB	Disposition
20	00	5000	SUSPEND
20	30	5000	PAY
20	32	5000	PAY
20	33	5000	PAY
20	34	5000	PAY
20	70	5000	PAY
20	72	5000	PAY
20	73	5000	PAY
20	74	5000	PAY
20	91	5000	SUSPEND

Claim Type: H - Home Health Claims **Member Plan:** ALL **Status:** Post

Location	Region	EOB	Disposition
20	00	5000	SUSPEND
20	30	5000	PAY
20	32	5000	PAY
20	33	5000	PAY
20	34	5000	PAY
20	70	5000	PAY
20	72	5000	PAY
20	73	5000	PAY
20	74	5000	PAY
20	91	5000	SUSPEND

Claim Type: L - Long Term Care Claims **Member Plan:** ALL **Status:** Post

Location	Region	EOB	Disposition

20	00	5000	SUSPEND
20	30	5000	PAY
20	32	5000	PAY
20	33	5000	PAY
20	34	5000	PAY
20	70	5000	PAY
20	72	5000	PAY
20	73	5000	PAY
20	74	5000	PAY
20	91	5000	SUSPEND

Claim Type: M - Professional Claims **Member Plan:** ALL **Status:** Post

Location	Region	EOB	Disposition
20	00	5000	SUSPEND
20	30	5000	PAY
20	32	5000	PAY
20	33	5000	PAY
20	34	5000	PAY
20	70	5000	PAY
20	72	5000	PAY
20	73	5000	PAY
20	74	5000	PAY
20	91	5000	SUSPEND

Claim Type: O - Outpatient Claims **Member Plan:** ALL **Status:** Post

Location	Region	EOB	Disposition
20	00	5000	SUSPEND
20	30	5000	PAY
20	32	5000	PAY
20	33	5000	PAY
20	34	5000	PAY
20	70	5000	PAY
20	72	5000	PAY
20	73	5000	PAY
20	74	5000	PAY
20	91	5000	SUSPEND

EOB: 5000 - THIS IS A DUPLICATE OF ANOTHER CLAIM.

ARC Code	ARC Description	Effective Date	End Date

18	Exact duplicate claim/service (Use only with Group Code OA except where state workers' compensation regulations requires CO)	19950101	22991231

EOB: 9999 - PROCESSED PER POLICY.

ARC Code	ARC Description	Effective Date	End Date
97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	19950101	22991231

METHOD OF CORRECTION:

There are several methods of correction (MOCs) that pertain to different claim types; please work appropriately. Click on the related ICN(s) in the related history. The related history can be associated with the same ICN or different ICN(s). For pharmacy related details, where the modifier is causing the edit to apply, please reference Attachment A related to modifiers.The following MOCs apply to both situations:

Medical/Medical Crossover claims:
The claim being submitted has the same member number, rendering provider number, dates of service, procedure code, NDC code (where applicable), all 4 modifiers match or are all blanks, as a paid claim in history and neither the current nor history claim has modifier AS or a mod to mod restriction modifier (see list of modifiers on the audit rules). Exception: For claims with a procedure code of T1015 (FQHC/RHC situations), set AU 5001 when the billing provider, dates of service, procedure code and primary diagnosis codes are the same.

Outpatient/Outpatient Crossover claims:
The claim being submitted has the same member number, billing provider number, first date of service on the detail, revenue code, procedure code, NDC Code (where applicable), all 4 modifiers match or are all spaces, as a paid claim in history. Exception 1: When the current and history claims or details have the same member, billing provider and first date of service on the detail but the revenue code is different, set AU 5001 when the procedure codes are the same (but not blanks) and neither claim has a modifier of 78. Exception 2: When the current and history claims or details have the same member, billing provider, first date of service on the detail, and revenue codes but the procedure codes are different, set AU 5001 when the revenue code is a flat fee revenue code that is not a Treatment room code and the procedure codes are surgical (see the audit rules for a list of surgical codes and revenue codes included on the audit). Exception 3: When the current and history claims or details have the same member, billing provider, first date of service on the detail, and revenue codes are the same but the procedure codes are different, set AU 5001 when the revenue code is a flat fee revenue code and the procedure codes on both details are not surgical (see the audit rules for a list of surgical codes and revenue codes included on the audit).

Home Health claims:
The claim being submitted has the same member number, billing provider number, From date of service on the detail, procedure code and all 4 modifiers (or modifiers are all blanks) as a paid claim in history. If a procedure code does not exist on the current claim, set AU 5001 if the revenue code is the same as a paid claim in history.

Long Term Care:
The claim being submitted has the same member number, billing provider number, From and last dates of service and revenue code as a paid claim in history. Note: The audit sets for different claims only.

Dental claims:
The current claim involves the same member number and has a procedure code that does not bypass dental dupe auditing (see audit rule configuration for list of codes), for the same rendering provider number, same from date of service, with the same procedure code, same tooth number and same area of the oral cavity as a paid claim in history.

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Attachment A (Pharmacy Related Modifiers):

Modifier on historical claim	Modifier on current claim	Override or Deny
JB	BLANK	DENY
BLANK	JB	DENY
JG	BLANK	DENY
BLANK	JG	DENY
RT	LT	PAY
LT	RT	PAY
LT	BLANK	DENY
TB	BLANK	DENY
BLANK	TB	DENY
PO	BLANK	DENY
BLANK	PO	DENY
PN	BLANK	DENY
BLANK	PN	DENY
JA	BLANK	DENY
BLANK	JA	DENY
GC	BLANK	DENY
BLANK	GC	DENY