Indiana Medicaid Resolutions Manual

NAME: **5001 EXACT DUPLICATE**

ERROR TYPE: Form Audit

HEADER/DETAIL: Detail

OVERRIDABLE: Y

ALLOW DENIAL: Y

DESCRIPTION:

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

CRITERIA:

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 spaces, 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 and From date of service on the detail, procedure code and all 4 modifiers (or modifiers are all blanks) as a paid claim in history. In addition, if a procedure code exists, same procedure code and all 4 modifiers are the same as a paid claim in history. If a procedure code does not exist on the current claim, same revenue code 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.

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	5001	DENY
20	80	5001	DENY
20	91	5001	SUSPEND
80	20	5001	DENY

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

Location	Region	EOB	Disposition
20	00	5001	DENY
20	80	5001	DENY
20	91	5001	SUSPEND

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

Location	Region	EOB	Disposition
20	00	5001	DENY
20	30	5001	DENY
20	32	5001	DENY
20	33	5001	DENY
20	34	5001	DENY
20	70	5001	DENY
20	72	5001	DENY
20	73	5001	DENY
20	74	5001	DENY
20	80	5001	DENY
20	91	5001	SUSPEND

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

Location	Region	EOB	Disposition
20	00	5001	DENY
20	80	5001	DENY
20	91	5001	SUSPEND

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

Location	Region	EOB	Disposition
20	00	5001	DENY
20	80	5001	DENY
20	91	5001	SUSPEND

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

Location	Region	EOB	Disposition
20	00	5001	DENY
20	80	5001	DENY
20	91	5001	SUSPEND

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

Location	Region	EOB	Disposition
20	00	5001	DENY

20	80	5001	SUSPEND
20	91	5001	SUSPEND

EOB: 5001 - 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:

Claim Type (B, C, D, H, L, M, O)

Claims setting this audit will systematically deny.

Special Batches (Region 91):
Special batched claims will need to have some approval from OMPP or some documentation indicating that this is not a duplicate.