Priority Health	BILLING POLICY No. 021
DUPLICATE CLAIMS	
Date of origin: Oct. 2023	**Review dates: 2/2025**

APPLIES TO
All plans

DEFINITION
This policy details our duplicate claim or services policy. This identifies when a provider or multiple providers are billing for the same services that may only be reimbursed one time.

POLICY SPECIFIC DETAILS
One claim per date of service should be reported by a given practitioner, provider group or facility for a service rendered.

Defining duplicate claims
Claims or claim lines are defined as duplicates when:

- The same practitioner, provider group or facility (same TIN, NPI, etc.) bills for the same date of service (DOS), same CPT or HCPCS or any combination of these criteria. Previously submitted and reimbursed claim(s) or the same claim have identical claim lines
- Another provider bills for a duplicate service, and the service is expected to be reported only once per date of service. (ex. Same Lab service from both hospital and reference lab; claims received for two global services when code is defined as professional only or technical only)

Should we identify duplicate claims:

- Documentation may be required to validate the services rendered.
- Subsequent claims flagged as duplicates won't be reimbursed.
- Claims paid and retrospectively identified as a duplicate will be adjusted and reimbursement recovered.
- If you disagree with a duplicate denial, follow our review and appeals process.

Providers can avoid duplicate denials by paying close attention to coding guidelines and Priority Health claim submission guidelines. For example:

- Use appropriate modifiers to reflect additional or repeated services
- Correctly resubmit claim(s) as corrected or replacement claim

Identifying duplicate overpayment
If you identify that a claim has been processed as a duplicate in error, you can take action. Review our Provider Manual page on corrections for overpayments.

DISCLAIMER
Priority Health's billing policies outline our guidelines to assist providers in accurate claim submissions and define reimbursement or coding requirements if the service is covered by a Priority Health member's benefit plan. The determination of visits, procedures, DME, supplies and other services or items for coverage under a member's benefit plan or authorization isn't being determined for reimbursement.

Authorization requirements and medical necessity requirements appropriate to procedure, diagnosis and frequency are still required. We use Current Procedural Terminology (CPT), Centers for Medicare and Medicaid Services (CMS), Michigan Department of Health and Human Services (MDHHS) and other defined medical coding guidelines for coding accuracy.

An authorization isn't a guarantee of payment when proper billing and coding requirements or adherence to our policies aren't followed. Proper billing and submission guidelines must be followed. We require industry standard, compliant codes defined by CPT, HCPCS and revenue codes for all claim submissions. CPT, HCPCPS, revenue codes, etc., can be reported only when the service has been performed and fully documented in the medical record to the highest level of specificity. Failure to document for services rendered or items supplied will result in a denial. To validate billing and coding accuracy, payment integrity pre- or post-claim reviews may be performed to prevent fraud, waste and abuse. Unless otherwise detailed in the policy, our billing policies apply to both participating and non-participating providers and facilities.

If guidelines detailed in government program regulations, defined in policies and contractual requirements aren't followed, Priority Health may:

- Reject or deny the claim
- Recover or recoup claim payment

An authorization on file for an item or services doesn't supersede coding, billing or reimbursement requirements.

These policies may be superseded by mandates defined in provider contracts or state, federal or CMS contracts or requirements. We make every effort to update our policies in a timely manner to align to these requirements or contracts. If there's a delay in implementation of a policy or requirement defined by state or federal law, as well as contract language, we reserve the right to recoup and/or recover claim payments to the effective dates per our policy. We reserve the right to update policies when necessary. Our most current policy will be made available in our Provider Manual.

CHANGE / REVIEW HISTORY

Date	Revisions made
Feb. 5, 2025	Added "Disclaimer" section