Duplicate claims policy

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.