Duplicate Services

Reimbursement Policy ID: RPC.0013.72AC

Recent review date: 09/2026

Reimbursement policies and their resulting edits are based on guidelines from established industry sources, such as the Centers for Medicare & Medicaid Services (CMS), the American Medical Association (AMA), state and federal regulatory agencies, and medical specialty professional societies. Reimbursement policies are intended as a general reference and do not constitute a contract or other guarantee of payment. The health plan may use reasonable discretion in interpreting and applying its policies to services provided in a particular case and may modify its policies at any time.

In making claim payment determinations, the health plan also uses coding terminology and methodologies based on accepted industry standards, including Current Procedural Terminology (CPT); the Healthcare Common Procedure Coding System (HCPCS); and the International Classification of Diseases,10th Revision, Clinical Modification (ICD-10-CM), and other relevant sources. Other factors that may affect payment include medical record documentation, legislative or regulatory mandates, a provider's contract, a member's eligibility in receiving covered services, submission of clean claims, and other health plan policies, and other relevant factors. These factors may supplement, modify, or in some cases supersede reimbursement policies.

This reimbursement policy applies to all health care services billed on a CMS-1500 form or its electronic equivalent, or when billed on a UB-04 form or its electronic equivalent.

To the extent that any procedure and/or diagnosis codes are specified in this policy, such inclusion is provided for reference purposes only, may not be all inclusive, and is not intended to serve as billing instructions. Listing of a code in this policy does not imply that the service described by the code is a covered or non-covered health service. Benefit coverage for health services is determined by federal, state, or contractual requirements and applicable laws that may require coverage for a specific service. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. Other Policies and Guidelines may apply.

Policy Overview

This policy describes the denial of duplicate claim submissions by providers contracted with the health plan.

A claim or claim line is considered a duplicate if payment of the same service, for the same patient, on the same date of service was processed to the same provider—whether it is to an individual physician or the same group practice with the same specialty.

Exceptions

N/A

Reimbursement Guidelines

The health plan has edits to prevent payment of duplicate claims. Exact duplicates of a claim or claim line will be denied. Claims or claim lines that align closely with a claim that was processed for payment are considered suspect duplicates, and they will also be denied. Providers should report multiple units of service for the same date of service on a single claim line. Subsequent claims with multiple units of service billed on the same date of service by the same provider will be denied as duplicates.

An associated modifier may indicate that a CPT/HCPCS code being billed is not a duplicate claim. For example, anatomical modifiers specify the area or part of the body on which certain procedures or non-evaluation and management services were performed. Clinical documentation must support the services being reported. See also Reimbursement Policy RPC.0006.72AC on Bilateral Procedures.

If a repeat procedure is performed by the same physician on the same day, the physician may need to indicate that the procedure was repeated subsequent to the original procedure. Modifier 76 is appended to the repeated procedure to indicate it was not a duplicate procedure for claim processing purposes.

Refer to CPT/HCPS manuals for complete descriptions of procedures and modifiers. Refer to Pennsylvania billing resources for fee schedules and other billing guidelines. Please note that a corrected claim must include the appropriate Frequency/Bill Type code to indicate that it is not a duplicate.

Definitions

Duplicate claim
A claim or claim line for which payment of the same service, for the same patient, on the same date of service, was processed to the same provider.

Same provider
A physician or other health care professional from the same group practice, with the exact same specialty and subspecialty, and reporting under the same Federal tax identification number (TIN).

Suspect duplicate claim
A claim or claim line that aligns with a claim that was processed for payment so closely that it is considered a duplicate claim.

Edit Sources

I. Current Procedural Terminology (CPT) and associated publications and services.
II. Healthcare Common Procedure Coding System (HCPCS).
III. International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM).
IV. Centers for Medicare & Medicaid Services (CMS).
V. The National Correct Coding Initiative (NCCI)
VI. Applicable Fee Schedules

Attachments

N/A

Associated Policies

RPC.0006.72AC Bilateral Procedures
RPC.0089.72AC Anatomical Modifiers

Policy History

09/2026	Reimbursement Policy Committee Approval
09/2026	• Addition of MUE billing resulting in a duplicate claim • Removed the next review date • Replaced the plan name with “the health plan”
11/2025	Reimbursement Policy Committee Approval
10/2025	Annual review • Minor revisions, addition of modifier 76 with associated policy
04/2025	Revised preamble
04/2024	Revised preamble
11/2023	Reimbursement Policy Committee Approval