To:	**MeridianHealth Providers**
From:	**MeridianHealth**
State:	Illinois
Line of Business:	Medicaid
Date:	July 2018
Re:	**Provider Billing Education: Duplicate Claim Submissions**

The Illinois Department of Healthcare and Family Services (HFS) and MeridianHealth (Meridian) are coming together to provide informative resources to improve successful provider billing. This guidance focuses on duplicate claim submission criteria when accepting encounter data from Meridian, as defined by HFS. The objective of this information is to help providers reduce the amount of duplicate claim rejections for Medicaid managed care claims.

NOTE: Community Mental Health Centers (CMHCs) must follow additional guidance to prevent duplicate claim submissions.

Institutional Billing Guidelines:

HFS defines a duplicate claim as more than one claim submitted to an MCO using the same criteria when billed on UB-04 or 837 institutional claim formats. Duplicating the Patient Medicaid ID, Billing NPI/Provider Number, Admit Through Discharge Date, and Bill Type will result in a UB-04/837Iclaim rejection.

HFS guidance to Meridian requires that providers submit only one claim using the above criteria. Claim lines should be used to bill for all services rendered. Failure to submit institutional claims according to these guidelines will result in payment of ONLY the first claim submitted. Additional claims billed using the same criteria will be rejected as a duplicate claim.

Institutional claims for emergency room (ER), outpatient observation services, and/or related ancillary services may be rejected for failure to adhere to the HFS guidance below. Hospitals must follow this guidance when billing ER/OBV and ancillary services on UB-04/837I claim forms:

1. All ancillary services related to an inpatient hospital stay must be billed together with room and board charges on a single inpatient claim
2. All outpatient laboratory, radiology, drugs, and other hospital ancillary services provided during an ER/OR visit must be billed on one claim and not as separate claims. These services are billed on the inpatient claim for a subsequent admission if the date of admission is the same as the date the patient began the episode of care in the ER. These services are billed together with the ER/OBV charge on a separate outpatient claim if the patient began the episode of care in the ER on a date other than the date of the subsequent admission