Bureau of TennCare
IS Policy Manual

Last Revised--11/14/2007

Policy No: BTC-Pol-Enc-200608-009	
Subject: Definition of TennCare Duplicate Encounters	
Approval: Encounter Policy Workgroup	**Date:** 10/27/2006

PURPOSE OF POLICY STATEMENT: To clarify TennCare's position regarding the definition of a duplicate transaction in the encounter files sent in by the Managed Care Contractors (MCCs).

POLICY: The Bureau of TennCare is undergoing an initiative to review the submission of encounter data in order to improve the data integrity and to more accurately reflect claims adjudication and payments by the MCCs. The presence of duplicate encounter transactions is causing inconsistency in reporting. MCCs should not pay duplicate claims. The MCC is responsible for reviewing all encounter claims to ensure duplicates are not submitted to TennCare. The claim is considered a duplicate if:

1. The MCCs ICN was previously loaded in the TennCare or MCCs system.
2. The **professional** claim being submitted has the same rendering provider, recipient, dates of service, procedure code, and procedure code modifier as either a previously paid claim or another paid claim in the same file.
3. The **pharmacy** claim being submitted has the same billing provider, recipient, dates of service, prescription number and NDC(s) as either a previously paid claim or another paid claim in the same file.
4. The **institutional** claim being submitted has the same billing provider, recipient, revenue code, procedure code, procedure code modifier, dates of service, and claim type as either a previously paid claim or another paid claim in the same file.

5. The **dental** claim being submitted has the same recipient, dates of service, procedure code, tooth number, and quadrant.

Exceptions:

On professional claims, duplicate auditing should be bypassed if the same procedure codes and one of the following modifier conditions occur:

1) Either the history or current detail has a modifier of 26 and the other claim has a modifier 26 and either a 76 or 77.

2) Either the history or current detail and the other claim has one of the following modifiers: 50, 51, 59, 62, 76, 77, 91, A1-A9, AS, E1-E4, F1-F9, FA, KP, LT, QR, RT, SH, T1-T9, TA, WG, WS.

3) Procedure code 90472 - Immunization administration must be billed with an appropriate ICD-9 diagnosis code that describes the type of vaccine administered.

On all claims, duplicate auditing should be bypassed:

4) When a valid duplicate service modifier is appropriately furnished. See Medicare Claims Processing Manual, Chapter 12 – Part 30.M.

5) The service on the claim is one which CMS has identified as not a duplicate, and does not require a modifier to not be counted as a duplicate regardless of the number of repeats.

REFERENCE DOCUMENTS:

TennCare HIPAA Companion Guides
CMS Claims Processing Manuals
CMS HCPCS Listing

OFFICES OF PRIMARY RESPONSIBILITY:

- TennCare IS Division—to ensure that encounters are submitted to TennCare in the approved format
- Information Systems Management Contractor – to process encounters through the TCMIS system
- MCCs - to follow transaction requirements