PCHP Reimbursement Policy		
Topic: Same Day Duplicate or Subsequent Services	Policy Number: PCHP.RI.018	Policy Section: Administration
Last Modification Date:	Effective Date: 5/15/2025	

Policy Disclaimer:

Please ensure adherence to correct billing and submission protocols. Utilize industry-standard, compliant codes when submitting claims. Services should be coded using Current Procedure Terminology® (CPT), Healthcare Common Procedure Coding System (HCPCS), and/or revenue codes. These codes specify the services or procedures rendered and must be fully substantiated in the medical record or office notes upon billing. Our reimbursement policies apply uniformly to both participating and non-participating professional providers and facilities, unless stated otherwise.

Failure to comply with appropriate coding/billing guidelines or current reimbursement policies may result in actions by PCHP, including claim rejection or denial, claim payment recovery/recoupment, or reimbursement adjustment to accurately reflect the services provided.

These reimbursement policies are designed to support you in submitting accurate claims and to clarify the criteria for reimbursement if PCHP covers the service under the member's benefit plan; however, coverage determination for items such as, but not limited to service, procedure, item, do not guarantee reimbursement. All billed services must align with authorization and medical necessity guidelines.

These reimbursement policies may be overridden by mandates in provider contracts, state or federal regulations, or Centers for Medicare & Medicaid Services (CMS) requirements. PCHP strives to implement policy changes promptly; any delays may necessitate recoupment of claims payment to the effective date as outlined in the policy. We reserve the right to periodically review and update these policies as needed, with the most current version available on our website upon any revisions.

Policy:

Duplicate or subsequent services on the same day may be reimbursed if billed with an appropriate modifier, unless provider, state, federal, or CMS contracts and/or requirements indicate otherwise.

A service is considered a definite duplicate if some or all of the following elements on the claim match:

- Billed Charge Amount
- Date of Service
- Member Name and Member ID
- Provider of service/ Rendering provider.
- Type of service, based on procedure or revenue codes billed

A service is suspected duplicate if the following elements on the claim match:

- Date of service
- Member Name and Member ID
- Procedure code

Subsequent service is a service performed or provided for the same member more than once on the same date of service.

When an individual service is separated from a more complex or comprehensive service and billed independently on the same date:

- The claim line for the individual service will undergo code editing and may be subject to denial if both services are billed on the same claim.
- Services are billed on separate claims, they will be reviewed accordingly.

Modifiers indicating that an individual service is distinct and separate from a more comprehensive service are detailed in the Related Coding section provided below.

References:

This policy has been developed through consideration of the following:

CMS, Department of Health and Human Services, Texas Health and Human Services and all applicable agencies, National Correct Coding Initiative, National Uniform Billing Committee (NUBC), Code of Federal Regulations (CFR) Subpart A-Payments §447.26, Federal Register Vol. 76, No. 108- A. The Medicare Program and Quality Improvements Made in the Deficit Reduction Act of 2005 (DRA) (Pub. L. 109–171) and E. Section 2702 of the Affordable Care Act.

Policy History:

Description	Date
Policy Created	May 9, 2024
Policy Approved	January 30, 2025