# CHAPTER 9
# ADDENDUM A

## DUPLICATE CLAIMS SYSTEM DISPLAYED DATA FIELDS

| HCSR DATA ELEMENTS | |
|---|---|
| **FIELD NAME** | **DESCRIPTION** |
| **Sponsor SSAN** | Sponsor Social Security Number |
| **DOB** | Patient Date Of Birth |
| **DDS** | DEERS Dependent Suffix Code (DDS) |
| **Program Ind** | Program Indicator Code |
| **Provider Tax ID** | Provider Taxpayer Number |
| **Provider Sub ID** | Multiple Provider ID |
| **Proc Code/Proced Code** | Procedure Code |
| **Diagnosis** | Principle Treatment Diagnosis Code |
| **DRG** | Diagnosis Related Group Number |
| **Inst Admit Date** | Admission Date |
| **Inst Care Begin Date** | Institutional Care Begin Date; Blank For Non-Institutional |
| **Non-Inst Care Begin Date** | Non-Institutional Care Begin Date |
| **Inst Care End Date** | Institutional Care End Date; Blank For Non-Institutional |
| **Non-Inst Care End Date** | Non-Institutional Care End Date |
| **Billing Freq** | Billing Frequency Code (1 = Complete, 2 = Initial, 3 = Interim, 4 = Final) |
| **Billed Amount (Total)** | Amount Billed Total |
| **Billed Amount (Line)** | Non-Institutional Line Item Amount Billed Total |
| **Allowed Amount (Total)** | Amount Allowed |
| **Allowed Amount (Line)** | Non-Institutional Line Item Amount Allowed |
| **Place Serv** | Place Of Service |
| **Type Serv** | Type Of Service |
| **PTC Date** | Processed To Completion Date |
| **HCSR ICN** | Internal Control Number |
| **Suffix/SFX/S** | Control Number Suffix |
| **Time Stamp** | System time assigned when issuing an initial HCSR |
| **Proc FI** | HCSR FI Contractor Number |

| HCSR DATA ELEMENTS (CONTINUED) | |
|---|---|
| **FIELD NAME** | **DESCRIPTION** |
| **Processing Contract** | Contract Number |
| **Batch Sequence #** | Batch Sequence Number |
| **Voucher Sequence #** | Voucher Sequence Number |
| **Cycle Number** | TMA Processing Cycle (Year, Month, Cycle Number) |
| **Name** | Patient Name |
| **Age** | Patient Age |
| **Enrolled** | Enrollment Status |
| **Patient Zip Code** | Patient Zip Code |
| **Provider Zip Code** | Provider Zip Code |
| **Provider Affiliation** | Provider Contract Affiliation Code |
| **Provider Specialty** | Provider Specialty Code |
| **Type Institution** | Type Of Institution Code |
| **Disp** | Discharge Disposition |
| **Govt Pd Amount** | Amount Paid By Government Contractor |
| **L** | Claim Line Item Number |
| **HCSR Line #** | Non-Inst Adjustment Line Item Number; For Inst = 00 |
| **Adjust PTC Date** | Adjustment Processed to Completion Date |
| **Allowed Amount** | Claim Level Adjustment Allowed Amount for Institutional Claim<br>Line Item Level Adjustment Allowed Amount for Non-Institutional Claim |
| **Special Processing Code 1** | First Special Processing Code |
| **Special Processing Code 2** | Second Special Processing Code |
| **Special Processing Code 3** | Third Special Processing Code |
| **Special Rate Code** | Special Rate Code |
| **Pricing Code** | Pricing Code On Non-Institutional Line Item |
| ***CPT-4 Modifier 1*** | |
| ***CPT-4 Modifier 2*** | |

| GENERATED DATA ELEMENTS | |
|---|---|
| **FIELD NAME** | **DESCRIPTION** |
| **Set #** | Extract claim set control number. A unique reference to tie together a set of potential duplicate claims. |
| **Match Type** | Claim set match criteria category: EXACT MATCH, NEAR MATCH, DATE OVERLAP, CPT-4, CODE, OTHER. Determined during the initial extract and set construction. |
| **Claim Match** | Claim match criteria category. Same as claim set categories. |
| **M (match type code for line item)** | Line item match criteria category. Same as claim set categories. |
| **Risk** | Financially underwritten, non-financially underwritten indicator for claim. *Please note that for the purposes of this system:*<br>*Financially underwritten = Risk*<br>*Non-financially underwritten = Not-at-risk.* |
| **Mass Change Level** | The latest MASS CHANGE cluster rule applied to the claim. |
| **Patient Region** | Patient health service region code. |
| **Provider Region** | Provider health service region code. |
| **Owner FI** | **Owner FI** represents, for the claim set, the contractor that has been assigned responsibility for resolving particular potential duplicate claim sets. Typically, all claims within a set will have the same responsible FI/Contractor (**Resp FI**), in which case the **Owner FI** will be the same as the responsible FI/Contractor. However, for "multi-contractor" claim sets where the responsible FI/Contractors are not the same for all claims within the set, an **Owner FI** is originally assigned by the system to be the responsible FI/Contractor from the claim within the set having the latest processed-to-completion date. |
| **Resp FI / Rsp FI** | **Resp FI** or **Rsp FI** represents, for the claim, the contractor that is currently responsible for administering the claim. When the claim is initially extracted from HCSR, the **Resp FI** is identical to the **Proc FI** (Processing FI). However, contract awarding and transitions may require claim administration by a new contractor, in which case the system will assign a new **Resp FI** for the claim. |

| GENERATED DATA ELEMENTS (CONTINUED) | |
|---|---|
| **FIELD NAME** | **DESCRIPTION** |
| **Owner Region** | **Owner Region** is a narrative descriptor of the contract number and represents, for the claim set, the Owner FI/ Contractor region. Typically, all claims within a set will have the same **Responsible Contract**, in which case the **Owner Region** will be the same as the **Responsible Contract**. However, for multi-contractor claim sets where the contractors are not the same for all claims within the set, an **Owner Region** is assigned by the system to be the **Responsible Contract** from the claim within the set having the latest processed-to-completion date. The initial assignment is done in tandem with the assignment of **Owner FI**. |
| **Responsible Contract** | **Responsible Contract** represents, for the claim, the contract under which the claim is currently administered. When the claim is initially extracted from HCSR, the **Responsible Contract** is identical to the **Processing Contract**. However, contract awarding and transitions may require claim administration under a new contract, in which case the system will assign a new **Responsible Contract** for the claim. |
| **Dupe?** | **Dupe?** is an indicator to describe whether or not the claim is a duplicate. During the extract processes **Dupe?** will be set to "N" (no) for the base claim within a set and will be set to blank for the remaining claims. [Also, as is noted in this section, the set status will be *OPEN*, as some claims within the set have not been marked as duplicates or non-duplicates.]<br>As the user determines whether claims are duplicates, the **Dupe?** for the remaining claims will be set to "Y" (yes) for duplicates or "N" for non-duplicates; the base claim designation may be changed if appropriate. [After all claims within the set have been marked and an amount identified for recoupment has been entered (when appropriate), the system will change the status to *PENDING*.] |
| **Reason Code** | **Reason Code** is a code used for each claim within a set to designate why the claim in the set is or is not a duplicate. During the initial loading of a set into the system, the base claim within a set will be assigned (in conjunction with **Dupe?** being set to "N") a reason code of BASE representing initial submission. The system will provide an option list of valid codes intended to cover the majority of possible conditions and a code for an "other" option for the occasions when the condition cannot be classified. Some **Reason Code** selections will require an additional explanation field for further elaboration. |

| GENERATED DATA ELEMENTS (CONTINUED) | |
|---|---|
| **FIELD NAME** | **DESCRIPTION** |
| **HCSR Adjust?** | **HCSR Adjust?** is a flag for the user to designate which adjustment or cancellation corrects the duplicate condition. All adjustments and cancellations that apply are checked "Y" (yes), and those that do no apply can be left blank or checked "N" (no). The HCSR Adjustment field is the sum (for the claim) of allowed dollar amounts for those that apply. Display screens enable **HCSR Adjust?** to be checked for any institutional claim and any non-institutional line item. |
| **Status** | **Status** indicates the claim set life cycle phase from initial system loading to final purging. **Status** is set by the system as a consequence of specific user actions or periodic system functions. |
| **Identified Recoup** | **Identified Recoup** is a dollar amount that is entered by the user upon initial determination that a claim is a duplicate. It represents the amount of overpayment for the claim that has been identified for recoupment. |
| **Actual Recoup** | **Actual Recoup** is a dollar amount that is entered by the user upon completion of recoupment for a duplicate claim. It represents the amount of overpayment for the claim that has actually been recouped. |
| **HCSR Adjustment** | **HCSR Adjustment** is a dollar amount that is maintained by the system (not by the user) to accumulate HCSR adjustments or cancellations made during resolution of a duplicate claim. It is calculated as the sum of all adjustment and cancellation allowed amounts (**Allowed Amount**) that have been flagged by the user as being associated with correcting the duplicate. This is the sum of claim level allowed amounts for institutional claims and line item allowed amounts for non-institutional claims. |
| **ID Recoup** | **ID Recoup** is a dollar amount calculated by the system as the sum of **Identified Recoup** amounts for all claims within a set. It represents the total amount of overpayment for the claim set that has been identified for recoupment. |
| **Actual Recoup** | **Actual Recoup** is a dollar amount calculated by the system as the sum of claim level actual recoupment amounts for all claims within a set. It represents the total amount of overpayment for the set that has actually been recouped. |
| **Adjust Amount** | **Adjustment Amount** is a dollar amount calculated by the system as the sum of **HCSR Adjustment** amounts for all claims within a set. It represents the total amount of adjustments and cancellations that have been flagged by the user as being associated with correcting all duplicate claims within the set. |

| GENERATED DATA ELEMENTS (CONTINUED) | |
|---|---|
| **FIELD NAME** | **DESCRIPTION** |
| **Initial Load Date** | **Initial Load Date** represents the date the claim set was initially loaded into the system. The LASTDATE reflects the most recent claim set update date - for specific types of updates. |
| **Current Load Date** | **Current Load Date** represents the date the claim set was initially loaded into the system or the date set ownership changed, or the date a new claim was appended to the set, whichever is the latest date. |
| **Last Update Date** | **Last Update Date** represents the most recent date a claim set was updated. Changes to the following **will** change the **Last Update Date**: Status, Match Type, Multi-FI Indicator, Owner FI, Owner Region, ID Recoup, Actual Recoup, Set Adjustment Amount, and Adjust Indicator. The **Last Update Date** will **not** change solely due to a change to: User Defined Codes, Dupe? field, Solicited (S?) Indicator, HCSR Adjust?, Reason Code, Reason Code Explanation, or Notepad. |
| **S?** | **S?** is the Solicited Indicator. See *Section 5* for definition. |
| **Set Level User Defined Code** | See *Section 5* for definition. |