DUPLICATE CLAIMS DATA

The Duplicate Claims System *(DCS)* performs several functions for the maintenance of the *DCS d*atabases. First, it identifies, selects, and extracts potential duplicate claims from the Health Care Service Records (HCSRs) database. It then groups potential duplicate claims into sets and stores these claims in the *DCS* Active *d*atabase. Subsequently, it identifies adjustment and cancellation transactions processed by the HCSR system associated with claims in the *DCS* Active and History *d*atabases and attaches these adjustment transactions to their associated sets. In attaching adjustment/cancellation HCSR transactions to their associated sets, the system enables users to verify that duplicate payment records have been removed from the HCSR database.

The *DCS* performs these functions separate and apart from the proprietary, claims processing systems maintained and operated by the Managed Care Support Contractors *(MCSCs) and the TRICARE Dual Eligible Fiscal Intermediary Contractor (TDEFIC)*. Proprietary claims processing systems maintain claim and encounter processing histories which document the activities associated with the processing and payment of claims and encounters. These systems generate HCSRs for submission to the *TRICARE Management Activity (*TMA*)*. HCSRs reflect specific claim/encounter processing activity and document health care services and associated payment actions. HCSRs are in a uniform format to permit claims processing data from various contractors to be integrated into a single database.

Contractors are required to prevent duplicate claim payments. Despite a variety of automated and manual controls established for this purpose, duplicate payments are made. These duplicate payments, appearing as duplicate HCSRs, are detectable by TMA. When duplicate payments are identified, contractors are expected to initiate recoupment action. Upon receipt of the refunds or offsets, adjustment HCSRs should be submitted to reflect the recoupments. When adjustments are added to the HCSR database, the duplicate payments are corrected, and the duplicate conditions are removed from the HCSR database.

The correction of the HCSR database is a critical function of the *DCS*. Not only do duplicate HCSRs represent overpayments, their very existence in the HCSR database skew statistics and reduce the confidence of analyses and projections based on this data. Data integrity is compromised if the database is not purged of HCSRs representing duplicate payments.

The *DCS* is not intended to replace or substitute for contractor developed, maintained, and operated duplicate detection and resolution activities within their own claims processing systems. The *DCS* does not pretend to capture all potential duplicate conditions. If it did, the volume of claim sets would soon become unmanageable. The *DCS* is an adjunct to contractor systems. It detects and displays most common duplicate conditions but not all. Contractors are still expected to employ their own systems to prevent, detect, and resolve duplicate payment conditions.

1.0. SOURCE OF DUPLICATE CLAIMS DATA

The following describes how HCSRs became *DCS* sets and what happened to these sets over time within the DCS.

1.1. Contractors submitted HCSRs approximately daily to the Defense Information Systems Agency (DISA) site at Mechanicsburg, Pennsylvania where the HCSRs *were* housed on an IBM-compatible mainframe.

1.2. On a monthly basis, TMA processed the HCSRs received during the previous month and compared *them* to the previous 12 months of HCSR Net data to identify potential duplicate claims. The identified potential duplicate claims became the DCS monthly extract.

1.3. *TMA transferred the monthly extracts to the DB2 Server where they were processed and placed into the DCS Active database.*

1.4. *Now,* TMA processes the daily HCSR data received from the contractors and extracts any adjustments and cancellations to HCSRs previously identified as potential duplicates in *the* monthly extract and that reside in the DCS. This extract becomes the DCS daily extract.

1.5. TMA transfers the *daily* extracts to the *DB2* Server where they are processed and placed into the DCS *Active d*atabase.

1.6. DCS users work the sets in the DCS Active *d*atabase.

1.7. After specified conditions have been met and time periods have elapsed, DCS sets are moved to the DCS History *d*atabase.

1.8. After a specified period of time, the DCS sets are deleted from the DCS History *d*atabase.

2.0. CRITERIA USED TO SELECT POTENTIAL DUPLICATE CLAIMS

The *DCS* uses the criteria described on the following pages to extract HCSR data and load the *DCS d*atabases. The *DCS* inspects up to 14 HCSR data fields in each claim record and, if the claims match on one of the criteria categories, it extracts and groups these claims into sets. The criteria used by the system identifies claims with a high probability of being actual duplicates.

2.1. Match Criteria For Institutional Claims

The following categories of match criteria are used to identify and link two or more matched institutional claims. Figure 9-3-1 shows the specific HCSR data field match criteria used to select potential institutional duplicate claims.

Exact Match	All 14 fields match.
Near Match	Six fields match and the lesser Billed Amount is within 10% of the larger Billed Amount.

Date Overlap Four fields match and the beginning date of care of one claim falls between the beginning and ending dates of another.

Other Five fields match.

FIGURE 9-3-1 DATA FIELD MATCH CRITERIA FOR INSTITUTIONAL CLAIMS

FIELD NAME	OTHER	DATE OVERLAP	NEAR MATCH	EXACT MATCH
SPONSOR SSAN	✔	✔	✔	✔
DEERS DEPN SUFFIX	✔	✔	✔	✔
PATIENT DOB				✔
PROGRAM INDICATOR				✔
PROVIDER TAX ID	✔	✔	✔	✔
PROVIDER SUB ID	✔	✔	✔	✔
ADMIT DATE				✔
BILL FREQUENCY				✔
BILLED AMOUNT			**± 10% ****	✔
ALLOWED AMOUNT				✔
CARE BEGIN DATE	✔	**OVERLAP ***	✔	✔
CARE END DATE			✔	✔
PRIN DIAGNOSIS				✔
DRG CODE				✔

* The system determines date overlap as follows: (a) the begin date of care on one claim must be greater than the begin date of care on the other claim and less than the end date of care on the other claim, or (b) the begin date of care on one claim is equal to the begin date of care on the other claim(s) and the end dates of care are not equal.

** The system calculates ± 10% of the Billed Amount as follows: (a) the system takes the higher of the billed amounts and multiplies it by 90%; (b) the system then compares the lower billed amount from the other claim(s) to the 90% figure; (c) the lower billed amount(s) must be ≥ 90% of the higher billed amount.

2.2. Match Criteria For Non-Institutional Claims

The following categories of match criteria are used to identify and link two or more matched non-institutional claims. Figure 9-3-2, shows the specific HCSR data field match criteria used to select potential non-institutional duplicate claims.

Exact Match All 14 fields match.

Near Match Seven fields match and the lesser Billed Amount is within 10% of the larger Billed Amount.

CPT-4 Code Match Six fields and the first three characters of the procedure code match.

Other Six fields match.

FIGURE 9-3-2 DATA FIELD MATCH CRITERIA FOR NON-INSTITUTIONAL CLAIMS

FIELD NAME	OTHER	CPT-4 CODE	NEAR MATCH	EXACT MATCH
CLAIM LEVEL				
SPONSOR SSAN	✔	✔	✔	✔
DEERS DEPN SUFFIX	✔	✔	✔	✔
PATIENT DOB				✔
PROGRAM INDICATOR				✔
PROVIDER TAX ID	✔	✔	✔	✔
PROVIDER SUB ID	✔	✔	✔	✔
PRIN DIAGNOSIS				✔
LINE ITEM LEVEL				
PLACE OF SERVICE				✔
TYPE OF SERVICE				✔
CARE BEGIN DATE	✔	✔	✔	✔
CARE END DATE			✔	✔
BILLED AMOUNT		✔	**± 10% ****	✔
ALLOWED AMOUNT				✔
PROCED CODE	✔	**posn 1-3 ***	✔	✔

* The procedure code of one line item is not equal to the procedure code of the other line item but the first three characters of the procedure codes are equal.

** The system calculates ± 10% of the Billed Amount as follows: (a) the system takes the higher of the billed amounts and multiplies it by 90%; (b) the system then compares the lower billed amount from the other claim(s) to the 90% figure; (c) the lower billed amount(s) must be ≥ 90% of the higher billed amount.

2.3. Exclusions

2.3.1. Exclusion Of Certain Claims

The *DCS* excludes claims from the extract if they do not meet specific minimum dollar thresholds and other criteria. An individual claim is excluded if:

2.3.1.1. The Government paid amount at the claim level is $0.00.

2.3.1.2. The total allowed amount is less than $30.00.

2.3.1.3. The claim's program indicator is 'D' (Drug).

2.3.1.4. The claim's type of submission code is 'B', 'D', 'E', or 'O' (adjustment or cancellation to a prior non-HCSR claim or 100% paid by other health insurance).

2.3.1.5. The claim level allowed amount on a non-financially underwritten institutional potential duplicate is less than $30.00.

2.3.1.6. The claim level allowed amount on an financially underwritten institutional potential duplicate is less than $50.00.

2.3.1.7. The sum of the line item level allowed amounts on a non-financially underwritten non-institutional potential duplicate is less than $30.00.

2.3.1.8. The sum of the line item level allowed amounts on an financially underwritten non-institutional potential duplicate is less than $50.00.

2.3.2. Exclusion Of Certain Line Items

The *DCS* excludes line items from the extract if the line item procedure code (HCPCS or CPT-4) is one of the following:

HCPCS	CPT-4[1]	DESCRIPTION
A4000 - A4999	06888	Nutrition Equipment/Supplies - Purchase
A5000 - A6500	06942	Other Equipment/Supplies - Purchase
R _ _ _ _	76499	Radiographic Procedure
P _ _ _ _	84999	Clinical Chemistry Test
P _ _ _ _	88305	Tissue Exam By Pathologist
	90593	Whole Blood Charges
	90594	Professional Components Charge
	90595	Outpatient Hospital - Physician's Charge
	90596	Outpatient Hospital - Recovery Room Charge
	90597	Outpatient Hospital - Operating Room Charge
	90599	Outpatient Hospital - Emergency Room Charge
J _ _ _ _	90782	Injection (SC)/(IM)
J _ _ _ _	90784	Injection (IV)
	94799	Unlisted Pulmonary Service Or Procedures
	99070	Special Supplies
	99088	Other Room, Ancillary and Drug Charges
	99592	Hospital Outpatient Birthing Room Charges

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2.3.3. Other Exclusions

After potential duplicate claims have been identified and grouped into claim sets, a final test is applied to exclude certain types of claim sets least likely to contain actual duplicate claims. Claim sets are excluded if they meet any of the following conditions:

2.3.3.1. The claim set contains less than two claims after the elimination of claims in the set due to any of the previously listed exclusion criteria.

2.3.3.2. The set is a "Mother-Baby" claim set and contains no more than two claims, where one claim has a "6..." series principal diagnosis code (mother) and the other claim has a "V..." series principal diagnosis code (baby). (Applies only to institutional claims.)

2.3.3.3. The set is a "Pseudo" DEERS Dependent Suffix (DDS) claim set and contains no more than two claims, where the DDS on both claims is '75' and the names on the claims are not the same.

2.3.3.4. The set is a "Multiple Birth" claim set and contains no more than two claims, where both claims have "V31..." through "V39..." series principal diagnosis codes. (Applies only to institutional claims.)

2.3.3.5. The set contains no more than two line items and each have a 99283 CPT[1] procedure code and the program indicator is an 'I' on one claim and a 'N' on the other.

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