

CLAIM SETS AND THE CLAIM SET LIFE CYCLE

An understanding of claim sets and the claim set life cycle is a prerequisite for using the Duplicate Claims System (*DCS*). All potential duplicate claims are grouped into sets. Each claim set is unique. Each claim set is assigned a unique and sequential claim set number for reference and control purposes.

1.0. DEFINITION OF A CLAIM SET

A claim set is composed of two or more Health Care Service Records (HCSRs) meeting either one of four institutional match criteria, or one of four non-institutional match criteria described in [Section 3, paragraph 2.0](#). These match criteria are used by the system to identify and select claims that are potential duplicates.

Each claim set contains one and only one claim record that is initially assigned by the system to be the BASE claim, signifying the claim with the earliest processed to completion (*PTC*) date. By default, the system assumes that the BASE claim is the one least likely (with exceptions) to be a duplicate of another claim in the set because it was processed and paid before the other claim(s) in the set. The non-BASE claim(s) are considered to be potential duplicates.

The assignment of the BASE claim also applies to sets containing claims that were processed by two different contractors. These sets are referred to as multi-contractor sets. In multi-contractor sets, the duplicate payment is assumed to be a result of a jurisdictional processing error. In such cases, the claim with the earliest *PTC* date could be the actual duplicate. In both single contractor claim sets and multi-contractor claim sets, the contractor is able to change the BASE claim assignment and assign a different claim in the set as the BASE claim.

1.1. Institutional Claim Sets

The *DCS* applies *the* institutional match criteria to institutional claims at the claim level to identify potential duplicates. In general, an institutional claim will appear in only one set. If, however, a contractor submits a HCSR adjustment and changes a claim's date of service, the claim may subsequently appear in another set. When a claim appears in more than one set, the *Internal Control Number (ICN)* of the claim will be displayed in the CLAIM SET SCREEN in white letters and numbers. Additional claims may be added to a set at any time, providing they meet the match criteria.

EXAMPLE: If institutional claim A and institutional claim B are identified as potential duplicates, they will appear in Claim Set 1. If another claim, institutional claim C, is identified as a potential duplicate of either claim A or claim B, the system will add claim C to Claim Set 1. If an adjustment to claim B changes the dates of

service for the claim, claim B should be labeled as a non-duplicate claim in Claim Set 1. If claim B, as it appears with the revised dates of service, is identified as a potential duplicate of another institutional claim D, claims B and D will be grouped into a new Claim Set 2.

1.2. Non-Institutional Claim Sets

The *DCS* takes a different approach to identifying and linking potential non-institutional duplicate claims. Non-institutional potential duplicates are identified by comparing line item data of one claim with line item data of another claim.

NOTE: The *DCS* does not look for duplicates within a single claim; only among two or more claims.

When a line item of one non-institutional claim is identified as a potential duplicate of a line item of another non-institutional claim, the system groups the claims with the matching line items into a set.

For example, if line item number 5 of claim D is identified as a potential duplicate of line item 7 of claim E, the system will group the two potential duplicate line items into Claim Set 2. Any additional line items on claims D and E identified as potential duplicates of each other will also be included in Claim Set 2 if the beginning date of service is the same as the other potential duplicate line items in the set. All of the line items contained in Claim Set 2 must have the same beginning date of service.

1.2.1. Display Of Line Items In Non-Institutional Claim Sets

Non-institutional sets contain only those line items that have been identified as potential duplicates. Any line item not identified as a potential duplicate will not be included in the claim set. For example, if claim D contains five line items and claim E contains five line items, but only line items 1, 3, and 5 on claim D are identified as potential duplicates of line items 1, 2, and 4 on claim E, the claim set will include only those matched line items. Line items 2 and 4 from claim D and line items 3 and 5 from claim E will not appear in the claim set.

If, after a set has been established, the system detects potential duplicate line items from additional (e.g., a third and fourth) non-institutional claims that match the line items previously identified and have the same beginning dates of service, the system will add the new claims to the existing claim set. If, however, the identified line items from the third and fourth claims have different beginning dates of service, the system will create a new claim set composed of the matching line items from the third and fourth claims as long as they have identical beginning dates of service. If a contractor submits a HCSR adjustment that changes a line item's date of service, the line item may subsequently appear in another set.

For non-institutional potential duplicate claims to appear in the same claim set, the claims must have matching sponsor Social Security Account Numbers (*SSANs*); patient *Defense Enrollment Eligibility Reporting System* (*DEERS*) Dependent Suffixes (*DDSs*); provider tax ID and sub-ID numbers; and beginning dates of service.

1.2.2. Examples Of Non-Institutional Claim Sets

1.2.2.1. If Claim Set 4 contains two claims, F and G, with line item 2 on both claims showing services rendered to Sally Jones for an office visit with Dr. Smith on May 1, 1995, these line items would be matched up in one set. Later, however, if claims H and I come in for Sally Jones, both containing a line item for an office visit on October 1, 1995 with Dr. Smith, the system will group the line items with the October 1, 1995 date of service from claims H and I into a new claim set (Claim Set 5). The system will not include them in the claim set containing the line items for the May 1, 1995 office visit (Claim Set 4)---even though the line items are for the same procedure code, for the same beneficiary, and rendered by the same provider---because the beginning dates of care are different. The system will prevent contractors from having to research claims containing line items that are related to different episodes of care within the same claim set.

1.2.2.2. Claim Set 6 contains two claims, J and H, both containing one line item for services rendered to Sally Jones. The line items are for office visits with Dr. Smith on May 1, 1995. Later, claims L and M are received for Sally Jones containing two line items each. Line item 1 on claims L and M is for a minor outpatient surgical procedure for Sally Jones (removal of an ingrown toe nail) by Dr. Smith on May 1, 1995. Line item 2 on both claims *are* for office visits for Sally Jones on June 1, 1995 with Dr. Smith.

The system will match the May 1, 1995, line items from claims L and M with the line items from claims J and K. Claim Set 6 will now contain four line items from four different claims. However, because line item 2 on claims L and M have a different beginning date of service, (June 1, 1995), the system will create a new claim set (Claim Set 7) for line item 2 of claims L and M. These line items will not be added to Claim Set 6.

As a result, claims L and M will appear in both Claim Set 6 and Claim Set 7, with each claim set containing different line items. When the user is researching claims J, K, L, and M in Claim Set 6, the system will alert the user that claims L and M also appear in another claim set by changing the color of the ICN and suffix of Claims L and M from black to white. The system will permit the user to move directly to the "next" or "previous" claim set where L and M appear when the user double clicks on the ICNs shown in white.

1.3. Adjustments And Cancellations Associated With Claims In A Set

Following every HCSR processing cycle, generally on a daily basis, the *DCS* identifies all accepted adjustment and cancellation HCSRs which are associated with any of the HCSRs previously extracted as potential duplicates and residing in the *DCS* Active *database*. These adjustments and cancellations are extracted from the HCSR database and added to the applicable claim sets in the *DCS* Active *database*.

Adjustments to an institutional potential duplicate claim residing in the *DCS* are extracted and linked to the appropriate institutional claim set. Adjustments to a line item of a non-institutional potential duplicate claim residing in the *DCS* are extracted and linked to the appropriate non-institutional claim set.

The provisionally accepted adjustments will display in the DCS but cannot be used to correct the duplicate condition until a subsequent adjustment corrects the provisional condition.

1.4. ICNs Versus Claims

ICNs in the *DCS* do not necessarily equate to a claim. A “claim” is identified by an ICN and a suffix and a time stamp. The *DCS* considers different suffixes to the same ICN to be unique claims.

2.0. THE PURPOSE OF CLAIM SETS IN THE *DCS*

The primary purpose of creating claim sets is to establish a method by which potential duplicate claims are linked together. Claim sets are the distinguishing unit of categorization in the *DCS*. They identify a unique grouping of claims and line items that meet one or more match criteria and therefore are potential duplicates. Each claim set contains at least two claims. Each claim set is identified by:

- A Set Number
- A Status Code
- A Match Type
- An Owner FI
- An Owner Region

Each set also maintains totals of recoupment activities completed to date. Specifically, the set contains totals of the amounts identified for recoupment, totals of the amounts actually recouped, and totals of the allowed amounts of adjustment and cancellation HCSRs.

A claim set provides descriptive data about the claims in the set and the status of the set as it moves through the claim set life cycle to final resolution. HCSR data such as the ICN, HCSR Suffix, *PTC* date, sponsor *SSAN*, and other patient, provider and service data are displayed for each claim. Claim sets also contain fields that require contractor entry of data to resolve the set.

3.0. THE CLAIM SET LIFE CYCLE

The *DCS* is comprised of three databases. The first is the *DCS* Load *d*atabase where the HCSR extracts are processed for “loading” into the *DCS* Active *d*atabase. The second is *DCS* Active *d*atabase and the third is the *DCS* History *d*atabase. Sets are worked in the Active *d*atabase. Sets that have met certain criteria and that have resided in the Active *d*atabase for specified periods of time are archived to the History *d*atabase. See [Chapter 9, Section 3, paragraph 1.0.](#) and [paragraphs 4.3., 4.4., and 7.0.](#) for details regarding the *DCS* History *d*atabase. See [Chapter 9, Section 3, paragraph 1.0.](#) for information regarding the *DCS* Load *d*atabase.

The claim set life cycle is the foundation of the *DCS*. Claim sets in the *DCS* are given a claim set life cycle stage, i.e., a set status, to manage the resolution process. The claim set life cycle tracks each claim set as it moves through the resolution process.

In order to resolve a claim set, the contractor must identify actual duplicate claims payments, recoup the overpayments and remove duplicate conditions from the HCSR database. Or, the contractor must explain why the claims identified as potential duplicates

are not actual duplicates (e.g., twins who have received identical services). Additionally, a claim set may contain claims that are in fact actual duplicates yet none or only a portion of the monies identified for recoupment can be collected. In cases such as these, the system allows the contractor to resolve the claim set provided that an explanation for the absent or reduced recoupment is provided. The system has internal controls to ensure that the resolution process includes appropriate contractor action to fully or partially correct the duplicate condition in the HCSR database.

The claim set life cycle is composed of four stages. Each stage signifies a set status. The *Open* and *Pending* stages are considered “working” stages. Claim sets with an *Open* or *Pending* status have not been resolved. The *Closed* and *Validate* stages are considered “resolved” stages. Claim sets in the *Closed* or *Validate* status have been resolved and the appropriate rules of resolution satisfied. The four claim set life cycle stages are described below:

3.1. The Open Stage Of The Claim Set Life Cycle

This stage is the first stage in the claim set life cycle. The *Open* status is given to all claim sets when they are initially loaded into the *DCS* Active *d*atabase. In this stage, claim sets are shown with a status of *Open*, meaning that the claim set has not been researched by the contractor to determine:

- If actual duplicate payments were made on any of the claims in the set;
- The reason why a duplicate payment was made or why the apparent duplicate is not a duplicate; and
- The amount identified for recoupment, where applicable.

3.2. The Pending Stage Of The Claim Set Life Cycle

Normally, this is the second stage in the claim set life cycle. A set in *Pending* status means that the set is “Pending Recoupment”. This status indicates that the contractor has completed the necessary research to determine which claims are actual duplicates and which claims are non-duplicates. At least one claim in the set must be an actual duplicate in order for the set to be in the *Pending* status. Additionally, all actual duplicates must have an amount identified for recoupment.

3.3. The Closed Stage Of The Claim Set Life Cycle

This stage is considered the final stage in the claim set life cycle. It indicates that the claim set has met all of the criteria for the set to be fully resolved. The *Closed* status means that:

- All actual duplicate claims in the set have been identified with an amount identified for recoupment;
- All claims in the set have reason codes assigned;
- The full amount entered in the amount identified for recoupment was received in offsets or refunds; and
- Adjustments were submitted that reflect the recoupments and correct the duplicate conditions on the HCSR database.

A set also can be *Closed* when all claims in the set are identified as non-duplicates.

3.4. The Validate Stage Of The Claim Set Life Cycle

This stage in the claim set life cycle is a final, but conditional, stage. It indicates that the set did not meet the rules of resolution for fully resolving the set. For example, if only 80% of the amount identified for recoupment was collected, the system will not allow the set to be *Closed*. *Validate* status means that the full amount identified for recoupment could not be recovered and the reasons and circumstances for the reduced recoupment amount have been explained and that the contractor has “validated” that required recoupment procedures for uncollected debts have been followed. By having a separate status for sets involving incomplete recovery of identified recoupments, contractors and the TMA can readily identify the involved sets and claims within the *DCS*. *Validate* status means that:

- All actual duplicate claims in the set have an amount identified for recoupment;
- All claims in the set have reason codes assigned;
- The actual amounts recouped by refund or offset have been entered and that less than 100% of the amount identified for recoupment has been collected;
- An explanation for the lower recoupment amount has been entered;
- The HCSR database has been updated to reflect any refunds received or offsets taken; and
- Required recoupment procedures have been followed as they relate to uncollected debts. The explanation entered into the system must include the user’s name, the date, and the reason for the lower recoupment amount.

The *Validate* status is also used in one other circumstance. When the amount actually recouped is \$10.00 or less and the contractor chooses not to submit a HCSR adjustment, an explanation must be entered to that effect, and then the set can be resolved to a *Validate* status.

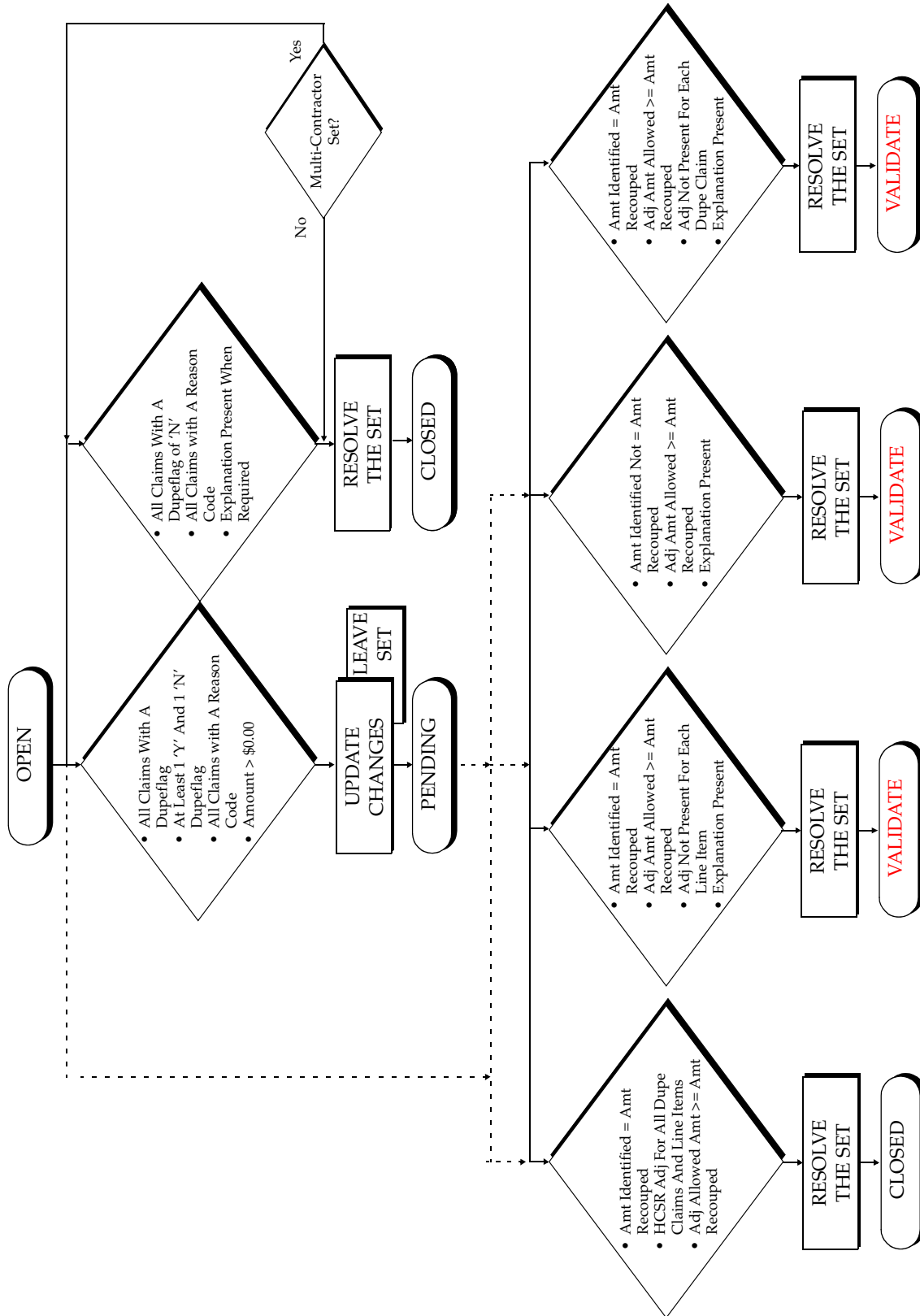
4.0. EXAMPLES OF SETS AT EACH STAGE OF THE CLAIM SET LIFE CYCLE

Each claim set has a status (e.g., *Open*) that corresponds to a stage of the claim set life cycle. The rules of resolution determine which status is given to each set. [Figure 9-4-1](#), is a flow diagram of the rules of resolution. It shows how the rules of resolution dictate changes to claim set status.

The status of a set changes as the user enters data in five fields:

- The **Dupe?** field
- The **Reason Code** field
- The **Identified Recoup** field
- The **Actual Recoup** field
- The **HCSR Adjust?** field

FIGURE 9-4-1 RULES OF RESOLUTION

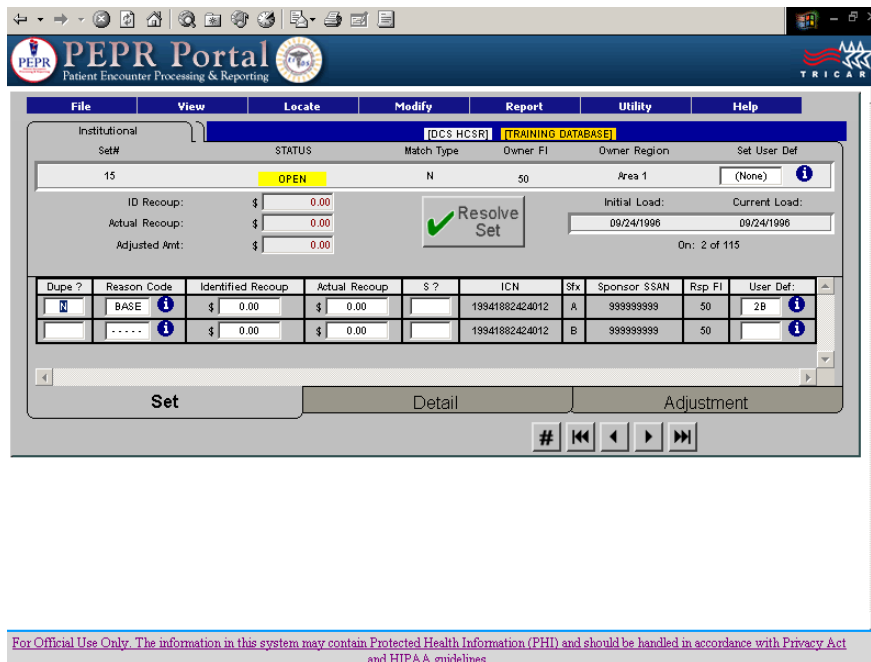


4.1. Open Claim Sets

This status indicates that the claim has not met the conditions defined in the rules of resolution for any other stage in the claim set life cycle. Essentially, *Open* claim sets are awaiting research by the contractor and subsequent action in the *DCS*.

An example of a claim set with an *Open* status is shown in [Figure 9-4-2](#). As shown in this figure, the contractor has not entered any data in the user-controlled fields of this set (e.g., **Dupe?**, **Reason Code**, **Identified Recoup**).

FIGURE 9-4-2 SAMPLE OPEN SET

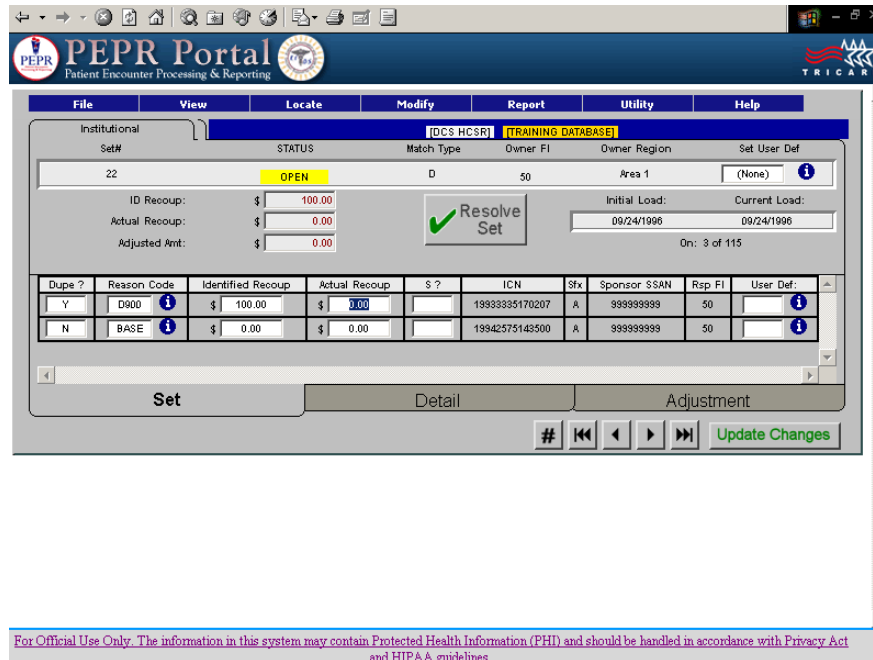


To move a set out of *Open* status, the user must enter data and invoke the rules of resolution. The user can invoke the rules of resolution by clicking the **UPDATE CHANGES** button to see if the status can be changed to *Pending*. The user also can invoke the rules of resolution by clicking the **RESOLVE THE SET** button to see if the status can be changed to *Closed* or *Validate*.

4.2. Pending Claim Sets

The status of a claim set can be changed from *Open* to *Pending* when a contractor completes the research and determines that the set contains one or more duplicates. After entering a 'Y' in the **Dupe?** field for each duplicate ([Figure 9-4-3](#)), identifying the reason for each duplicate, and identifying the amount that should be recouped for each duplicate, the contractor can invoke the rules of resolution to determine if the status of the set can be changed to *Pending*.

FIGURE 9-4-3 **OPEN TO PENDING CLAIM SET**



For Official Use Only. The information in this system may contain Protected Health Information (PHI) and should be handled in accordance with Privacy Act and HIPAA guidelines.

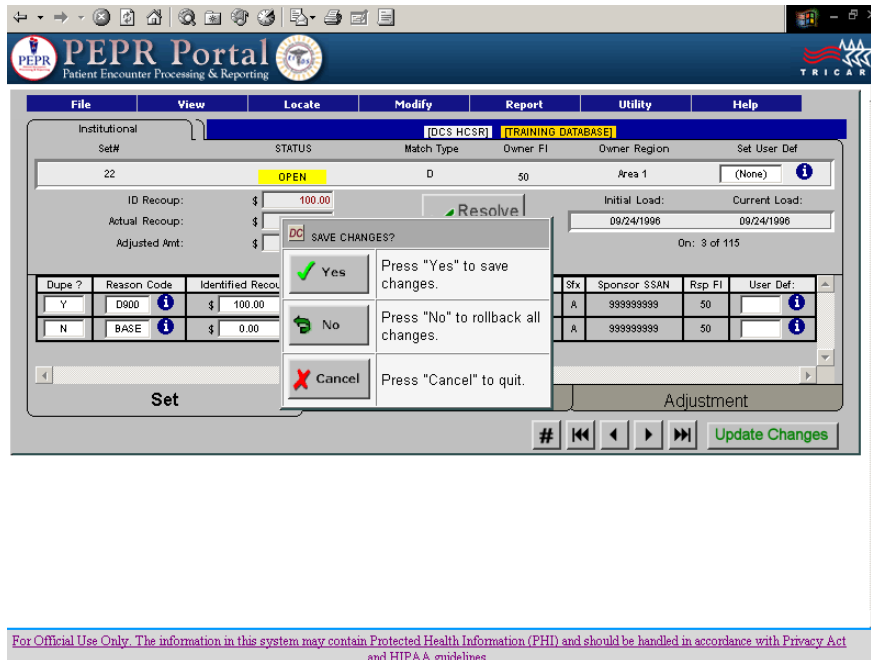
In order for the status of a claim set to be changed from *Open* to *Pending*, the contractor must either click the **UPDATE CHANGES** button or leave the claim set and allow the system to make the change. In either case, the system checks for the following conditions:

- All **Dupe?** fields have a 'Y' or 'N'
- There is at least one 'Y' and one 'N'
- There is one BASE claim
- All claims have a reason code
- All 'Y' claims have an amount identified for recoupment greater than \$0.00. (If multi-FI set, see Section 6, paragraph 2.4.)

To save changes, click the **UPDATE CHANGES** button. For an example of the **UPDATE CHANGES** SCREEN, see Figure 9-4-4. The following options are available:

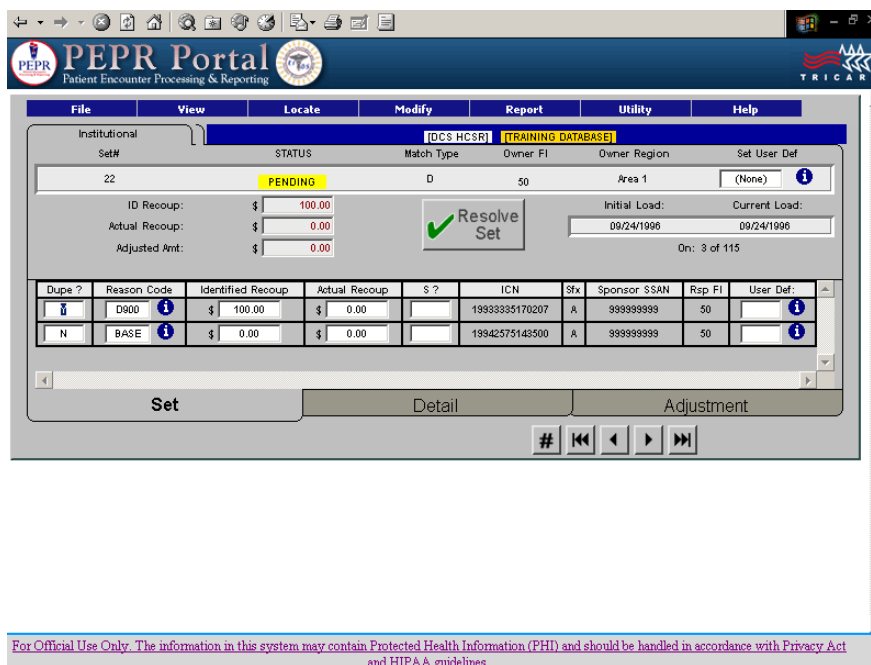
- "Yes" to save all changes.
- "No" to rollback all changes.
- "Cancel" to quit.

FIGURE 9-4-4 UPDATE CHANGES SCREEN



An example of a *Pending* claim set is shown in Figure 9-4-5. Contractors should not initiate recoupment action on an actual duplicate claim until the set has been moved to *Pending* status.

FIGURE 9-4-5 SAMPLE PENDING SET

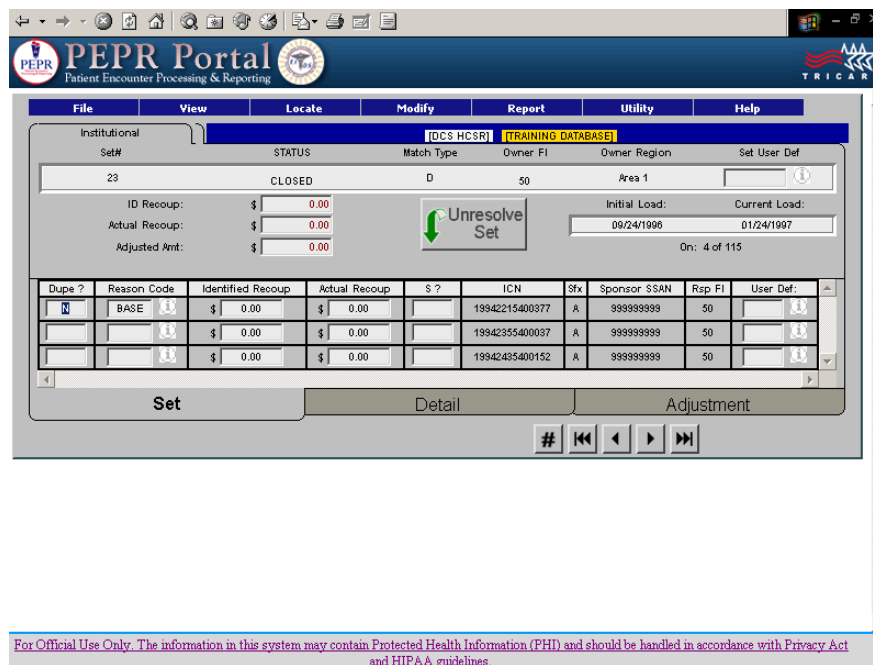


Because the **UPDATE CHANGES** button activates code that determines if a claim set meets the conditions for a *Pending* status, it also can be clicked to change the status from *Pending* back to *Open* when the *Pending* conditions are no longer met.

4.3. Closed Claim Sets

This status indicates that the claim set has met the conditions defined in the rules of resolution for full resolution. These conditions require full recoupment of all actual duplicate payments identified in the claim set. Also, HCSR adjustments corresponding to the amounts actually recouped must be flagged. If the *single contractor* set does not contain any actual duplicates, it can be resolved to a *Closed* status provided that each claim has a 'N' in the **Dupe?** field, a valid reason code and, if required, an explanation. *If it is a multi-contractor set, it must contain at least one claim with a 'Y' in the Dupe? field.*

FIGURE 9-4-6 SAMPLE CLOSED SET



An example of a claim set in *Closed* status is shown in *Figure 9-4-6*. As described in *Chapter 9, Section 2, paragraph 5.3.*, the **RESOLVE THE SET** button must be clicked to change the status of a claim set to *Closed*. Before this action, the status of the set may be *Open* or *Pending*. To meet the conditions for changing the status to *Closed* when one or more actual duplicates have been identified, the following conditions must be met:

- All **Dupe?** fields must have a 'Y' or 'N'.
- There must be at least one 'Y' and one 'N' in the set.
- All claims must have a valid reason code (some reason codes require a free-text explanation).
- The total amount identified for recoupment must be greater than \$0.00.

- The total amount identified for recoupment must equal the total amount actually recouped.
- The total HCSR adjustment allowed amounts flagged must be equal to or greater than the total amount actually recouped.
- Every duplicate claim and every duplicate line item must have a corresponding HCSR adjustment.

If no actual duplicates have been identified in a set, the following conditions must be met to change the status to *Closed*:

- All claims in the set must have a 'N' in the **Dupe?** field.
- All claims in the set must have a valid 'N' reason code.
- All **Identified Recoup** and **Actual Recoup** fields must equal \$0.00.

Closed claim sets remain on the DCS Active *d*atabase for two years, at which time they are moved to the DCS History *d*atabase where they are kept for an additional seven years. The system does not allow users to modify any of the fields in a *Closed* set unless the set is "unresolved" (i.e., moved back to the *Open* or *Pending* status by clicking the **UNRESOLVE THE SET** button). *Closed* sets in the DCS History *d*atabase are deleted after seven years.

4.4. Validate Claim Sets

This status indicates that the claim set has been resolved but the resolution did not meet the *Closed* status conditions, i.e., the full amount was not refunded or offset. The set may meet one of the four conditions for changing the status to *Validate*, as shown in [Figure 9-4-7](#).

FIGURE 9-4-7 CONDITIONS FOR CHANGING CLAIM SET STATUS TO VALIDATE

CONDITION 1	CONDITION 2	CONDITION 3	CONDITION 4
The total amount identified for recoupment is not equal to the total amount actually recouped.	The total amount identified for recoupment is equal to the total amount actually recouped.	The total amount identified for recoupment is equal to the total amount actually recouped.	The total amount recouped is less than or equal to \$10.00.
and	and	and	and
The sum of the allowed amount(s) for all selected adjustments is greater than or equal to the total amount actually recouped.	The sum of the allowed amount(s) for all selected adjustments is greater than or equal to the total amount actually recouped.	The sum of the allowed amount(s) for all selected adjustments is equal to or greater than the total amount actually recouped.	No adjustment was submitted by the contractor for the \$10.00 or less recoupment.

FIGURE 9-4-7 CONDITIONS FOR CHANGING CLAIM SET STATUS TO VALIDATE (CONTINUED)

CONDITION 1	CONDITION 2	CONDITION 3	CONDITION 4
and	and	and	and
The user enters an explanation for the discrepancy in the total amount identified for recoupment and the total amount actually recouped.	There is not a selected adjustment for every claim with a Dupe? of 'Y'.	There is at least one selected adjustment for every claim with a Dupe? of 'Y'.	The user enters an explanation that no HCSR adjustment will be submitted for a refund of \$10.00 or less.
	and	and	
	The user enters an explanation for the discrepancy in the number of adjustments flagged and the number of claims with a Dupe? of 'Y'.	There is not a selected adjustment for every line item in every non-institutional claim with a Dupe? of 'Y'.	
		and	
		The user enters an explanation for the discrepancy in the adjustment line items flagged and the line items with a Dupe? of 'Y'.	

An example of a claim set with a *Validate* status is shown in [Figure 9-4-8](#). As shown in this figure, the sum of the amount identified for recoupment, the sum of the amount actually recouped, and the sum of the associated HCSR adjustment allowed amounts satisfy condition 1 for changing the status to *Validate*.

When a user clicks the **RESOLVE** button to resolve a set that does not meet the full recoupment conditions required to change the status to *Closed*, the system will present the user with the condition(s) under which full recoupment requirements were not met. The system will then prompt the user to continue with resolution. If the user elects to continue and the set meets one of the *Validate* conditions, the system will display a pop-up screen requesting an explanation for the *Validate* status. The user is required to type in their name, the date, and explanation for the *Validate* situation.

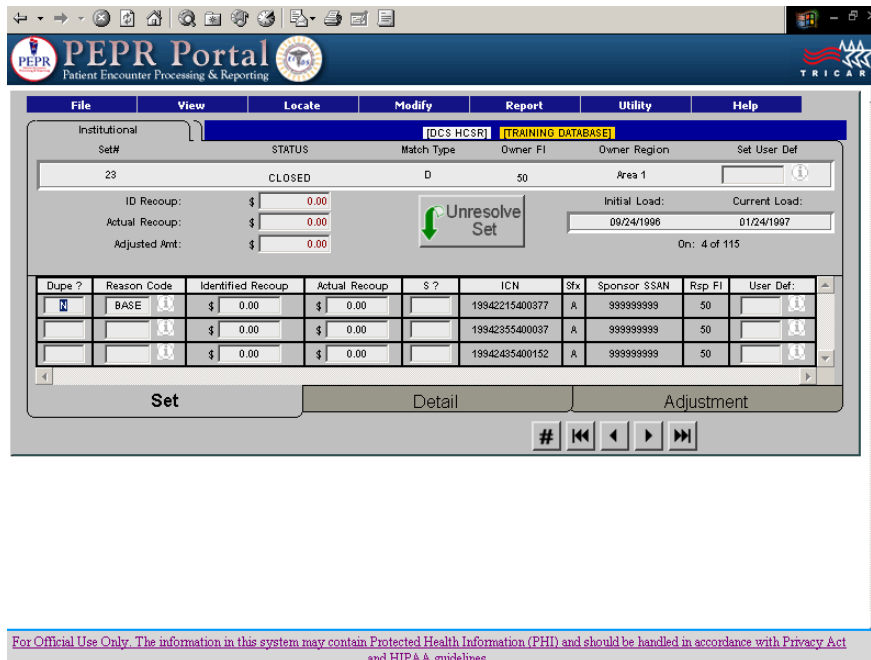
Validate claim sets remain on the DCS Active *d*atabase for five years, at which time they are moved to the DCS History *d*atabase where they are kept for an additional seven years. The system does not allow users to modify any of the fields in a *Validate* set unless the set is "unresolved" (i.e., moved to an *Open* or *Pending* status by clicking the **UNRESOLVE SET** button). *Validate* sets in the DCS History *d*atabase are deleted after seven years.

FIGURE 9-4-8 SAMPLE VALIDATE SET



It should be noted that any *Closed* or *Validate* set may be moved from *Closed* or *Validate* status back to a *Pending* or *Open* status in the DCS Active database by clicking the **UNRESOLVE SET** button (Figure 9-4-9). It should also be noted that if a new potential duplicate claim is identified which belongs in a *Closed* or *Validate* set residing in the DCS Active database, the system will add the new potential duplicate to the *Closed* or *Validate* set and change the status of the set to *Open* or *Pending*.

FIGURE 9-4-9 UNRESOLVE SET



5.0. APPENDING NEW CLAIMS TO EXISTING SETS DURING THE MONTHLY EXTRACT CYCLE

During each monthly extract cycle, new claim sets are added to the *DCS* Active *d*atabase. At the same time, if a new claim is identified as a potential duplicate of a claim in an existing set, it is added to the existing set. These sets are called appended sets. As the system appends these new claims to their appropriate sets, the system determines if the current **Owner FI** should be changed. It also determines if the status of the set should be changed.

5.1. Determining The Owner FI Of Appended Sets

The system applies the general rule of assigning the **Owner FI** to the **Responsible FI** of the claim with the latest PTC date if the status of the set is *Open* or *Closed*. If the status of the set is *Pending* or *Validate*, the system ignores this rule and leaves the current assignment of the **Owner FI**.

5.2. Determining The Status Of Appended Sets

All single contractor appended sets become *Open* sets. All multi-contractor appended sets are moved out of a resolved status (i.e., *Closed* or *Validate*) to a working status (i.e., *Open* or *Pending*). For multi-contractor appended sets, the following changes are applied:

- Appended sets in a *Closed* status are changed to *Open* status.
- Appended sets in a *Validate* status are changed to *Pending* status.
- Appended sets in a *Pending* status remain *Pending* sets.
- Appended sets in an *Open* status remain *Open* sets.

6.0. LOAD DATES

The *DCS* assigns two Load Dates (**Initial Load Date** and **Current Load Date**) to each set when loaded to the *DCS*. When a set is first loaded, both the **Initial Load Date** and the **Current Load Date** are the same. The **Initial Load Date** remains unchanged throughout the life cycle of the set. The **Current Load Date**, which is used in calculating compliance with the performance standards for the *DCS* (see [Section 9, paragraph 8.0.](#)), may change. There are two circumstances under which the **Current Load Date** could change. These circumstances are:

- When the **Owner FI** changes.
- When a set is appended with a new claim.

7.0. HISTORY DATABASE

The *DCS* History *d*atabase contains sets that had been in the *DCS* Active *d*atabase in *Closed* or *Validate* status for either two or five years respectively. The data in the History *d*atabase is read only. While users cannot change any data in the History *d*atabase, they can run reports. Certain TMA and contractor users have permission to “Unarchive” a set in the History *d*atabase (i.e., move the set back to the *DCS* Active *d*atabase where changes may be made. (See [Section 2, paragraph 1.0.](#), for instructions for accessing the History *d*atabase.)

