Chapter 9 Section 3

# Duplicate Claims Data

The Duplicate Claims System (DCS) performs several functions for the maintenance of the DCS databases. First, it identifies, selects, and extracts potential duplicate claims from the TRICARE Encounter Data (TED) database. It then groups potential duplicate claims into sets and stores these claims in the DCS Active database. Subsequently, it identifies adjustment and cancellation transactions processed by the TED system associated with claims in the DCS Active and History databases and attaches these adjustment transactions to their associated sets. In attaching adjustment/cancellation TED records to their associated sets, the system enables users to verify that duplicate payment records have been removed from the TED 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 TEDs for submission to the TRICARE Management Activity (TMA). TEDs reflect specific claim/encounter processing activity and document health care services and associated payment actions. TEDs 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 TEDs, are detectable by TMA. When duplicate payments are identified, contractors are expected to initiate recoupment action. Upon receipt of the refunds or offsets, adjustment TEDs should be submitted to reflect the recoupments. When adjustments are added to the TED database, the duplicate payments are corrected, and the duplicate conditions are removed from the TED database.

The correction of the TED database is a critical function of the DCS. Not only do duplicate TEDs represent overpayments, their very existence in the TED 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 TEDs 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 TEDs become DCS sets and what happens to these sets over time within the DCS.

**1.1** Contractors submit TEDs approximately daily. The TEDs are maintained on a TED database.

**1.2** On a monthly basis, TMA reads the TED database and compares the TEDs received during the previous month to TEDs received during the previous 12 months of TED Net data to identify potential duplicate claims. The identified potential duplicate TEDs become the DCS monthly extract.

**1.3** TMA also processes the daily TED data received from the contractors and extracts any TED adjustments and cancellations to TEDs previously identified as potential duplicates in a monthly extract and that reside in the DCS. These extracts become the DCS daily extract.

**1.4** TMA transfers the extracts to the DB2 Server platform where they are processed and placed into the DCS Active database.

**1.5** DCS users work the sets in the DCS Active database.

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

**1.7** After a specified period of time, the DCS sets are deleted from the DCS History database.

The DCS databases receive TED data through two extracts. The first extract is performed monthly, when TEDs submitted by contractors during the previous month are compared with TEDs submitted during the previous 12 months. Applying five different match criteria for institutional and non-institutional claims (four for each type), the system detects potential duplicate claims and selects these for extraction. See paragraph 2.0, for a description of the five match criteria.

Institutional potential duplicates are identified by the application of the match criteria at the claim level. Non-institutional potential duplicates are identified at the line item level. This distinction is important in understanding how institutional and non-institutional claims are displayed within the claim sets. Refer to Section 4, for details regarding claim set composition.

The second extract is performed following the processing of each payment record cycle, generally on a daily basis. The system maintains a table of all claims selected as potential duplicates during the first extract, and extracts adjustments and cancellations associated with these potential duplicates during the second extract. The system attaches the adjustments and cancellations to the appropriate DCS sets where users can access them.

The DCS databases store claim level data for both institutional and non-institutional claims. Examples of claim level data are: Internal Control Number (ICN), sponsor Social Security Number (SSN), Patient ID, diagnosis code, and the date the TED was processed to completion (PTC).

The system also stores line item data for non-institutional claims. Examples of line item detailed data are: procedure code, place of service, type of service, care begin and end dates.

Addendum A, contains a description of the data elements in the DCS databases.

## 2.0 CRITERIA USED TO SELECT POTENTIAL DUPLICATE CLAIMS

The DCS uses the criteria described on the following pages to extract TED data and load the DCS databases. Prior to the National Provider Identifier (NPI) implementation, the DCS inspects up to 12 TED data fields in each claim record; on or after the NPI implementation, 14 TED data fields in each claim record. 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 Prior To The NPI Implementation

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 TED data field match criteria used to select potential institutional duplicate claims.

| | |
|---|---|
| **Exact Match** | All 12 fields match. |
| **Near Match** | Five fields match and the lesser Billed Amount is within 10% of the larger Billed Amount. |
| **Date Overlap** | Three fields match and the beginning date of care of one claim falls between the beginning and ending dates of another. |
| **Other** | Four fields match. |
| **Other Inst** | Three fields (Patient ID, National Provider Identifier (NPI) - Type II, and Care Begin Date) **OR** Four fields (Patient ID, Provider ID, Provider Sub ID, and Care Begin Date) |

### FIGURE 9.3-1 DATA FIELD MATCH CRITERIA FOR INSTITUTIONAL CLAIMS PRIOR TO THE NPI IMPLEMENTATION

| FIELD NAME | OTHER | DATE OVERLAP | NEAR MATCH | EXACT MATCH |
|---|---|---|---|---|
| PATIENT ID | X | X | X | X |
| PATIENT DOB | | | | X |
| PROVIDER TAX ID | X | X | X | X |
| PROVIDER SUB ID | X | X | X | X |
| ADMIT DATE | | | | X |
| BILL FREQUENCY | | | | X |
| BILLED AMOUNT | | | ± 10%** | X |
| ALLOWED AMOUNT | | | | X |
| CARE BEGIN DATE | X | OVERLAP* | X | X |
| CARE END DATE | | | X | X |
| PRIN DIAGNOSIS | | | | X |
| DRG CODE | | | | X |

* 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 Institutional Claims On Or After The NPI Implementation

The following categories of match criteria are used to identify and link two or more matched institutional claims. Figure 9.3-2, shows the specific TED data field match criteria used to select potential institutional duplicate claims.

| | |
|---|---|
| **Exact Match** | All 14 fields match. |
| **Near Match** | Four fields match and the lesser Billed Amount is within 10% of the larger Billed Amount. |
| **Date Overlap** | Two fields match and the beginning date of care of one claim falls between the beginning and ending dates of another. |
| **Other** | Three fields match. |

### FIGURE 9.3-2 DATA FIELD MATCH CRITERIA FOR INSTITUTIONAL CLAIMS ON OR AFTER THE NPI IMPLEMENTATION

| FIELD NAME | OTHER | DATE OVERLAP | NEAR MATCH | EXACT MATCH |
|---|---|---|---|---|
| PATIENT ID | X | X | X | X |
| PATIENT DOB | | | | X |
| PROVIDER ID | | | | X |
| PROVIDER SUB ID | | | | X |
| NPI - TYPE II | X | X | X | X |
| ADMIT DATE | | | | X |
| BILL FREQUENCY | | | | X |
| BILLED AMOUNT | | | ± 10%** | X |
| ALLOWED AMOUNT | | | | X |
| CARE BEGIN DATE | X | OVERLAP* | X | X |
| CARE END DATE | | | X | X |
| PRIN DIAGNOSIS | | | | X |
| DRG CODE | | | | X |

* 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.

## 2.3 Match Criteria For Non-Institutional Claims Prior To The NPI Implementation

The following categories of match criteria are used to identify and link two or more matched non-institutional claims. Figure 9.3-3, shows the specific TED data field match criteria used to select potential non-institutional duplicate claims.

| | |
|---|---|
| **Exact Match** | All 12 fields match. |
| **Near Match** | Six fields match and the lesser Billed Amount is within 10% of the larger Billed Amount. |
| **CPT-4 Code Match** | Five fields and the first three characters of the procedure code match. |
| **Other** | Five fields match. |

**FIGURE 9.3-3 DATA FIELD MATCH CRITERIA FOR NON-INSTITUTIONAL CLAIMS**

| FIELD NAME | OTHER | CPT-4 CODE | NEAR MATCH | EXACT MATCH |
|---|---|---|---|---|
| **CLAIM LEVEL** | | | | |
| PATIENT ID | **X** | **X** | **X** | **X** |
| PATIENT DOB | | | | **X** |
| PRIN DIAGNOSIS | | | | **X** |
| **LINE ITEM LEVEL** | | | | |
| PROVIDER TAX NBR | **X** | **X** | **X** | **X** |
| PROVIDER SUB ID | **X** | **X** | **X** | **X** |
| PLACE OF SERVICE | | | | **X** |
| TYPE OF SERVICE | | | | **X** |
| CARE BEGIN DATE | **X** | **X** | **X** | **X** |
| CARE END DATE | | | 4 | **X** |
| BILLED AMOUNT | | **X** | **± 10%**** | **X** |
| ALLOWED AMOUNT | | | | **X** |
| PROCED CODE | **X** | **posn 1-3*** | **X** | **X** |

* 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.

## 2.4 Match Criteria For Non-Institutional Claims On Or After The NPI Implementation

The following categories of match criteria are used to identify and link two or more matched non-institutional claims. Figure 9.3-4, shows the specific TED data field match criteria used to select potential non- institutional duplicate claims.

| | |
|---|---|
| **Exact Match** | All 14 fields match. |
| **Near Match** | Five fields match and the lesser Billed Amount is within 10% of the larger Billed Amount. |
| **CPT-4 Code Match** | Four fields and the first three characters of the procedure code match. |
| **Other** | Four fields match. |
| **Other Inst** | Four fields. |

**FIGURE 9.3-4 DATA FIELD MATCH CRITERIA FOR NON-INSTITUTIONAL CLAIMS ON OR AFTER THE NPI IMPLEMENTATION**

| FIELD NAME | OTHER | OTHER | CPT-4 CODE | CPT-4 CODE | NEAR MATCH | NEAR MATCH | EXACT MATCH |
|---|---|---|---|---|---|---|---|
| **CLAIM LEVEL** | | | | | | | |
| PATIENT ID | X | X | X | X | X | X | X |
| PATIENT DOB | | | | | | | X |
| PROVIDER ID | | | | | | | X |
| PROVIDER SUB ID | | | | | | | X |
| NPI - TYPE II | X | | X | | X | | X |
| NPI - TYPE I | | X | | X | | X | X |
| PRIN DIAGNOSIS | | | | | | | X |
| **LINE ITEM LEVEL** | | | | | | | |
| PLACE OF SERVICE | | | | | | | X |
| TYPE OF SERVICE | | | | | | | X |
| CARE BEGIN DATE | X | X | X | X | X | X | X |
| CARE END DATE | | | | | X | X | X |
| BILLED AMOUNT | | | 4 | 4 | ± 10%** | ± 10%** | X |
| ALLOWED AMOUNT | | | | | | | X |
| PROCED CODE | X | X | POSN 1-3* | POSN 1-3* | X | X | X |

* 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.

## 2.5 Exclusions

### 2.5.1 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:

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

**2.5.1.2** The total allowed amount is less than $30.00.

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

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

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

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

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

**2.5.1.8** The second byte of the claim's type of service code is 'B' (Retail Drugs & Supplies) or 'M' (Mail Order Pharmacy Drugs & Supplies).

### 2.5.2 Exclusion Of Certain Line Items

**2.5.2.1** Before May 1, 2009 (implementation of the Outpatient Prospective Payment System (OPPS)), 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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**2.5.2.2** Anesthesia Assistants: When comparing two line items which have the same CPT-4 value (all five positions), if either of the CPT-4 Modifiers (CPT_4_1 or CPT_4_2) on one line item has a value of "QK" and either of the CPT-4 Modifiers on the other line item has a value of "QX" or a value of "QS".

**2.5.2.3** Assistant Surgeon Modifiers: When comparing two line items which have the same CPT-4 value (all five positions), if either of the CPT-4 Modifiers on one of the line items has a value of "80", "81", "82", or "AS" and neither of the CPT-4 Modifiers on the other line item has any of these values.

**2.5.2.4** Left/Right: When comparing two line items which have the same CPT-4 value (all five positions), if either of the CPT-4 Modifiers on one of the line items has a value of "RT" and either of the CPT-4 Modifiers on the other line item has a value of "LT".

**2.5.2.5** Professional/Technical Components: When comparing two line items which have the same CPT-4 value (all five positions), if either of the CPT-4 Modifiers on one of the line items has a value of "26" and either of the CPT-4 Modifiers on the other line item has a value of "TC".

**2.5.2.6** Ambulance Services: When comparing two line items which have the same CPT-4 value (all five positions) and that CPT-4 value is in the range of "A0021" through "A0999", if the values of the first CPT-4 Modifier (CPT_4_1) on the two line items are not equal.

### 2.5.3 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:

**2.5.3.1** 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.

**2.5.3.2** 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.)

**2.5.3.3** 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.)

- END -