

Duplicate Claims System

Chapter 12

All data in the Duplicate Claims System is protected by the Privacy Act of 1974 (P.L. 93-579)

I. OVERVIEW

The TRICARE Duplicate Claims System (Duplicate Claims System) was developed by the TRICARE Support Office (TSO) to automate the resolution of duplicate claim payments. The system facilitates the identification of actual duplicate claims payments, the initiation and tracking of recoupments, and the removal of duplicate records from the Health Care Service Record (HCSRs) database. The system also generates operational and management reports.

A. Preface

This document employs a number of conventions and application-specific terminology which may be unfamiliar to new users. Some of this terminology is directly related to concepts and activities pertaining to the system. Other terminology, although applied generally to the TRICARE community, takes on specific meaning in the system. For example, although there are differences in the services performed by Fiscal Intermediaries (FIs) and Managed Care Support Contractors (Contractors), in the interests of space and readability, this document uses the acronym FI/Contractor (or FI/Contractors for the plural) to mean both TRICARE FI and Managed Care Support Contractor organizations. Similarly, the term claim refers to claims or encounters or HCSRs.

For highlighting certain features of the system, we have employed several stylistic conventions in this document. All references to "buttons" a user must click on with a mouse device are shown in capital letters and bold type (e.g., **RESOLVE** button). All screen displays are shown in capital letters and italics (e.g., *CLAIM DETAIL SCREEN*). All field names are shown in upper and lower case letters and bold type (e.g., **Dupeflag** field). All claim set status categories are represented in upper and lower case with italics (e.g., *Open status*). Menu Bar selections are shown with the first letter underlined and in bold, just as they appear on the screen (e.g., **View function**). User selections to system prompts are generally shown within single quotes ('Y').

Users also should be aware that terminology used in this document is consistent with field names displayed on system screens. For example, the system uses three amount fields to resolve duplicate claims: amount identified for recoupment in field **Total Amt Ident Recoup**, amount actually recouped in field **Total Amt Actual Recoup**, and total HCSR adjustment allowed in field **Total Allowed HCSR Adj**.

In displaying these fields, the system captures the dollar amounts a user has entered for specific claims and computes totals for each of these fields. To ensure that the conventions and terms employed are fully understood by users, the Government will provide training and detailed instructions prior to system implementation.

All processes associated with the use of the system and all outputs and results generated by or associated with the system, including claims, encounters, dispositions, recoupments, collections, adjustments, and HCSRs, are subject to audit by the Government. The Duplicate Claims System is the property of the United States Government.

B. Definition of a Duplicate Claim Payment

A duplicate claim or encounter is a payment made for services for which reimbursement has already been made on one or more previous claims or encounters. In other words, two or more payments were made for the same service for the same beneficiary.

For the purposes of the Duplicate Claims System, when two or more payments are issued for the same service for the same beneficiary, the additional payments are considered actual duplicate payments, irrespective of whether the additional payments were justified or made in error, recoupment of the additional payments initiated, or refunds have been received.

The criterion to use in determining if a claim represents an actual duplicate payment is an affirmative answer to the following question:

Have any or all of the services paid on this claim been paid on a previous claim/encounter?

HCSR suffixes are treated as unique claims in the Duplicate Claims System. The same process and logic is applicable for duplicate suffixes. All duplicate HCSRs must ultimately be corrected through adjustments and cancellations to remove the duplicate condition from the HCSR database.

C. Development of the System

The Duplicate Claims System was developed to facilitate the identification and resolution of actual duplicate payments, increase accountability for recoupments, and verify the submission of HCSR adjustments to correct the duplicate condition in the HCSR database. The system was designed to optimize the efforts of both TSO staff and FI/Contractor staff in meeting their respective responsibilities regarding duplicate claim payments.

1. TSO and FI/Contractor Benefits

For the TSO, the system provides the tools to ensure that potential and actual duplicate payments are identified, recoupments are received, HCSR database corrections are made, and FI/Contractor standards of performance are met. For FI/Contractors, the system provides the tools to facilitate the research of potential duplicate payments and the identification of actual duplicate payments, document recoupment activities, and ensure that corrections to the HCSR database in the form of adjustments or cancellations are completed.

User defined, formatted reports are included in the Duplicate Claims System to help analyze trends, FI/Contractor performance, and processing or procedural problems in FI/Contractor operations.

2. System Objectives

The system was designed to meet the following objectives:

- a. To create a user-friendly, cost-effective, PC-based application using client/server technology;
- b. To preserve HCSR data integrity and display only those potential duplicate claims records applicable to each FI/Contractor;

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- c.** To provide as much data as possible to assist FI/Contractors in their efforts to identify actual duplicate payments;
- d.** To improve the detection of actual duplicate claims payments through the use of match criteria that have been found to be successful in identifying duplicate claim payments;
- e.** To automate methods for grouping and displaying institutional and non-institutional potential duplicate HCSRs to FI/Contractors for research and resolution;
- f.** To automate and simplify methods for FI/Contractors to report their determinations as to whether the identified potential duplicate HCSRs represent actual duplicate payments and, if they do, to report the corresponding amounts expected to be recouped;
- g.** To automate and simplify methods for FI/Contractors to report actual recoupment amounts and provide a mechanism for verifying that HCSR adjustments/cancellations were submitted and accepted, thereby correcting the duplicate condition in the HCSR database;
- h.** To automate methods to facilitate TSO and FI/Contractor audits and performance monitoring and;
- i.** To provide the capability to generate user defined reports and graphs.

In meeting these objectives, the system provides the tools to monitor timely FI/Contractor research and accurate identification of actual duplicate payments and aids in diagnosing processing problems which cause duplicate payments.

3. Justification for Development

The Duplicate Claims System is an on-line, user-friendly system that replaces potential duplicate claims paper reports. The Duplicate Claims System employs five different HCSR-based, duplicate detection match criteria to identify potential duplicate claims. It also accommodates FI/Contractor transitions, at-risk/not at-risk and in-system/out-of-system claims, and duplicate claims payments caused by jurisdictional processing errors.

In contrast to the old method of generating potential duplicate claims paper reports, the Duplicate Claims System displays sets of potential duplicate claims on PC screens and automates the duplicate claims resolution process. Figure I-1, Differences in Old Method and New Duplicate Claims System, (on the following page) compares the new system with the old paper process. The Duplicate Claims System improves TSO and FI/Contractor accountability of actual duplicate payments through the tracking of the amounts identified for recoupment, amounts actually received in refunds or offsets, and HCSR adjustments or cancellations submitted on receipt of the refunded or offset overpayments.

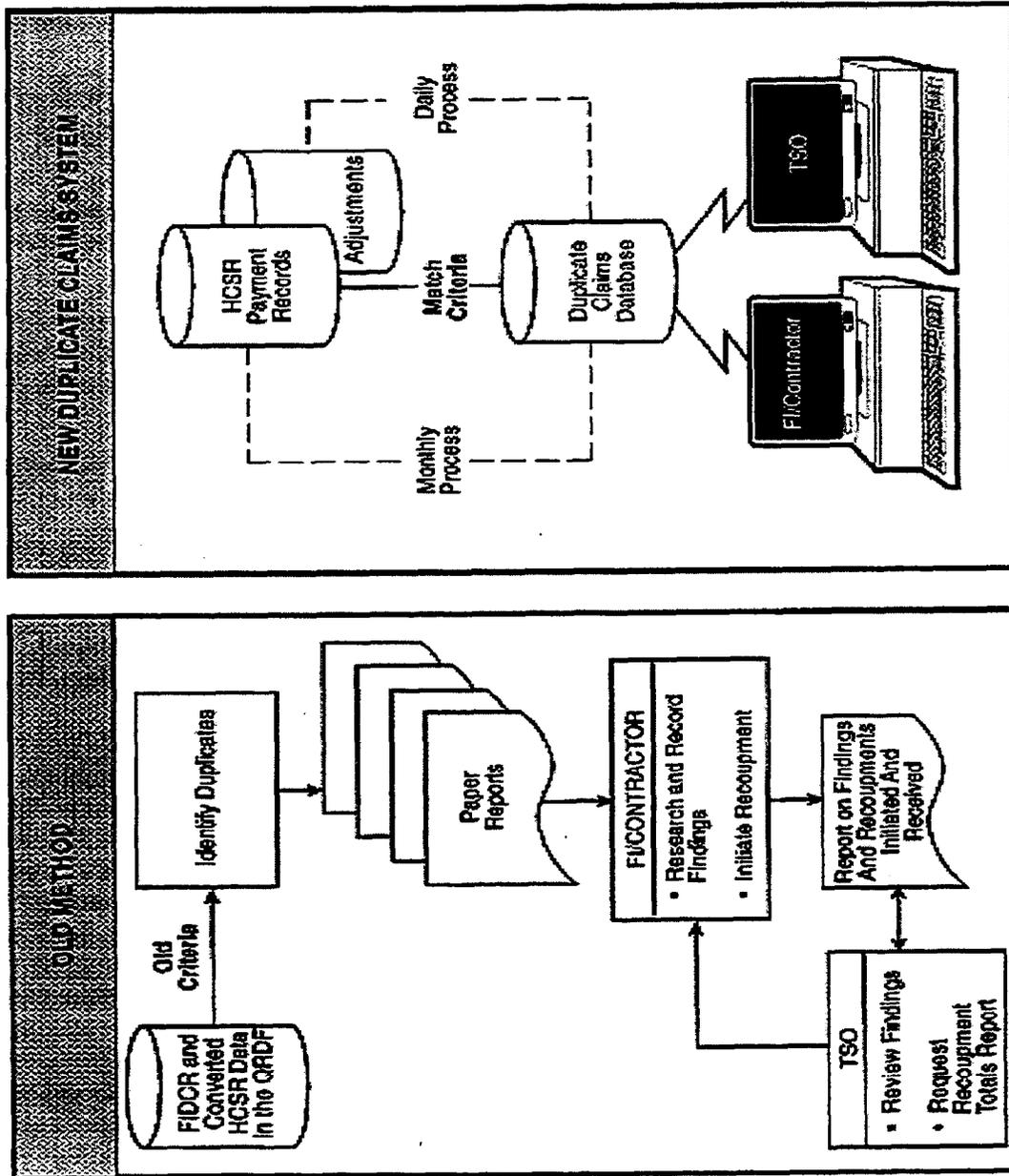


Figure I-1

DIFFERENCES IN OLD METHOD AND NEW DUPLICATE CLAIM SYSTEM

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D. Functional Capabilities of the Duplicate Claims System

The functional capabilities of the Duplicate Claims System supports the claims resolution process. The system also interfaces with the HCSR database to maintain the Duplicate Claims Database.

1. The Claims Resolution Process

The process by which duplicate claims are corrected in the Duplicate Claims System is referred to as the "claims resolution process". To initiate the claims resolution process, the Duplicate Claims System identifies and groups potential duplicate claims into "sets". This enables FI/Contractors to view matching claims and conduct the necessary research to determine if one or more claims in a set involve actual duplicate payments.

If one or more of the claims in a set represents an actual duplicate payment, the FI/Contractor will identify the duplicate payment by entering a 'Y' (for "Yes") in the **Dupeflag** field of that claim. If there are only two claims in the set, the other claim will have a 'N' (for "No") in the **Dupeflag** field to indicate it was the original or BASE claim. If there are more than two claims in the set, only one claim can be the BASE claim. The claims resolution process requires a FI/Contractor to enter a reason code to explain the cause of the duplicate payment and the dollar amount to be recouped. Upon receipt of the refund or offset, the FI/Contractor will enter the amount actually recouped.

After recording the amount actually recouped for the duplicate claim, the FI/Contractor must correct the duplicate condition in the HCSR database by submitting an adjustment/cancellation HCSR. When the HCSR adjustment has been processed and accepted, it will be transmitted to the Duplicate Claims System for processing. This processing, which generally occurs daily, adds adjustment transactions to appropriate sets. When the appropriate adjustment appears in a set, the FI/Contractor can verify removal of the duplicate condition from the HCSR database by flagging the adjustment transaction (i.e., by entering 'Y' in the **Adjustment Flag** field of the claim). All claims identified as a duplicate payment must have a 'Y' in the **Dupeflag** field, a valid reason code, and an amount identified for recoupment. Duplicate claims may also have an amount actually recouped and an adjustment amount.

The set (i.e., the duplicate claim) can now be resolved by clicking the **RESOLVE** button which invokes the "rules of resolution". (See ADP Manual, Chapter 12, Addendum E, Resolving A Duplicate Claim Set.) The rules state that a set can be resolved to a Closed status only if full recoupment has been received or if none of the claims in the set involve duplicate payments. If one of the claims is a duplicate payment but full recoupment was not received, the set can be resolved to a Validate status, providing an explanation has been entered to explain why full recoupment was not possible.

2. Extracting HCSR Data to Create and Maintain the Duplicate Claims Database

Using duplicate claims detection criteria, the Duplicate Claims System identifies potential duplicate claims from HCSRs residing in the HCSR database. These claims are extracted from the HCSR database on the TSO IBM-compatible mainframe. At the same time, additional data values required for system operation are added and the records are downloaded to a TSO Sun® server. HCSR records are then converted and imported into

SYBASE® tables. These tables become the Duplicate Claims Database. HCSR data and Duplicate Claims System data residing in the Duplicate Claims Database are accessible to users through the Duplicate Claims System application built in Paradox For Windows®.

E. System Design

In technical terms, the Duplicate Claims System is a "client/server" application. This term is used to describe an automated system that provides a user-friendly "client" environment on distributed personal computers which are interfaced with a transaction-based "server" environment that processes transactions, maintains databases, and optimizes the access and transfer of data between the two environments.

1. System Design Platforms

The Duplicate Claims System is composed of three platforms:

a. IBM-Compatible Mainframe Platform

The IBM-compatible mainframe platform is composed of an Amdahl 5995/665M MVS/ESA mainframe and operating system, and an IDMS database management system that maintains the HCSR database.

b. Sun Microsystem Platform

The Sun Microsystem platform is composed of Sun Microsystem SPARC Center 2000 computers, Solaris 2.3 (version of UNIX®) operating system), SYBASE® SQL Server database management system, SYBASE tables (i.e., the Duplicate Claims Database), and SYBASE Transact-SQL.

c. Personal Computer Platform

The PC platform is composed of personal computers installed at user sites. These computers are installed with a run-time version of Paradox For Windows® containing the Duplicate Claims System application. PCs also are installed with Borland International's SQL Links for Windows® Version 2.0, and SYBASE Net-Library for Windows® which provides the interface between the Duplicate Claims System and SYBASE tables.

Users at FI, Contractor, and TSO sites use the Duplicate Claims System's on-line screens built in Paradox For Windows® Version 5.0, running under Microsoft Windows For Workgroups® Version 3.11 or Microsoft Windows 95®. The Duplicate Claims System is a Paradox application based on a customized, graphical user interface employing full-color graphics, pull-down menus, and point-and-click mouse technology. It complies with standard Windows conventions and provides all required functionality for resolving potential duplicate claims.

The PC platform and Sun Microsystem platform will be upgraded as required to ensure compliance with TSO automation standards.

User screens include ease-of-use features such as buttons, scroll bars, shading, colors, VCR buttons, dialog boxes, user prompts, help messages, and error messages. These features enhance the display of claims data and facilitate movement from field to field, screen to screen, and claim set to claim set.

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2. Communications

The three system platforms described above and shown in Figure I-2, System Platforms (on the following page), operate independently. Data transmitted from one platform to another through interfaces and an in-house communications network. Users connect to this network and the Duplicate Claims System via a Government-supplied external communications network (e.g., 56 KB line, ISDN line, Non-classified IP Router Network). Instructions on establishing a connection to the network and the Duplicate Claims System will be provided by the Government.

3. Design Efficiencies

To optimize efficient use of system resources, the Duplicate Claims System employs on-line and background processing. Users work only in the on-line mode of operations. The background mode is used for data handling, database maintenance, and system administration.

a. On-line Processing Mode

The on-line processing mode contains system functionality for user activities, such as verifying that only authorized users gain access to system application software and duplicate claims data. Within this environment, the system provides menus for user functions, such as viewing potential duplicate claim sets through user-defined filters and criteria; locating specific claim sets by claim set number, sponsor Social Security Number (SSAN), or individual claim number (ICN); designating a claim as either an actual duplicate or a non-duplicate; entering identified and actual recoupment amounts; linking HCSR adjustments to identified actual duplicate claims; and resolving duplicate claim sets.

b. Background Mode

The background processing mode contains system functionality for system administration and maintenance, such as the interface with the HCSR database on the IBM mainframe to identify and extract potential duplicate claims and associated HCSR adjustments and cancellations. Background processing also maintains the necessary controls to group matching claims into sets and ensures that each FI/Contractor accesses only their own data.

F. System Functions

The Duplicate Claims System provides a broad range of user functions to support FI/Contractor and TSO activities and to ensure system integrity.

1. Claim Set Resolution Functions

As specified in all MCS and FI contracts, FIs and Contractors are responsible for both preventing and resolving duplicate claim payments. The Duplicate Claims System supports FI/Contractors in this responsibility by automating the process. The automated process defines the rules under which the resolution of claim sets can be completed, provides users with screens to enter the results of duplicate payment research, and maintains the necessary interfaces with the HCSR database to ensure and verify correction of the duplicate condition.

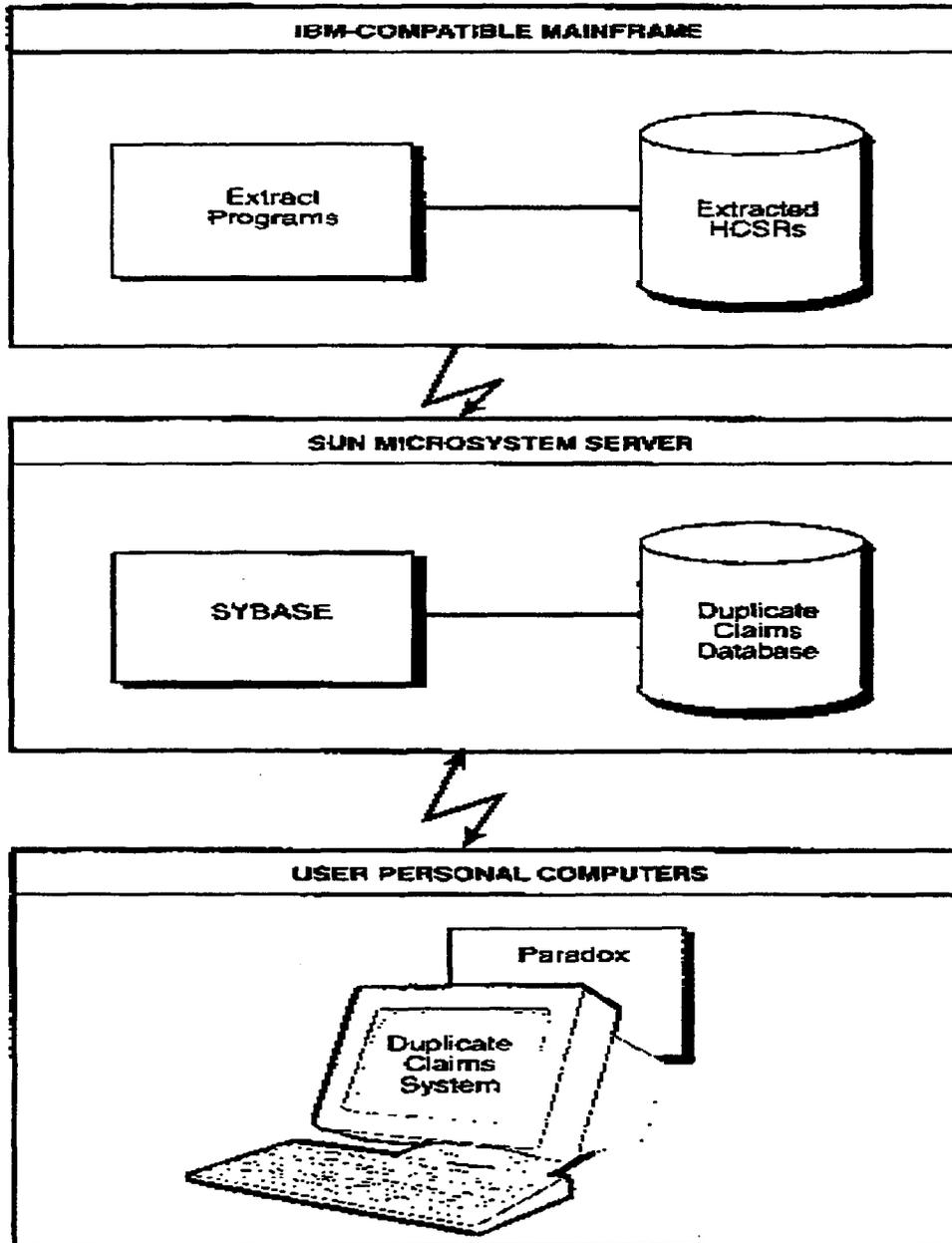


Figure I-2
SYSTEM PLATFORMS

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To resolve claim sets with one or more claims determined to contain actual duplicate payments, users are required to perform five basic activities:

- a. Enter a 'Y' or 'N' to indicate that a claim does or does not represent an actual duplicate payment;
- b. Select a reason code from a pre-defined list of reason codes for each claim, and enter a narrative description when necessary to explain why a claim does or does not represent an actual duplicate payment;
- c. Enter the dollar amount identified for recoupment for each actual duplicate claim;
- d. Enter the dollar amount actually received from the recoupment/offset action of each duplicate claim; and
- e. Submit the HCSR adjustment and link this adjustment to the actual duplicate claim after the adjustment has been processed by the HCSR system and received by the Duplicate Claims System.

2. Additional System Functions

A number of other tasks and data handling procedures facilitate duplicate claims resolution, and maintenance of system integrity. These tasks and data handling procedures include:

- a. Verifying user authorization through passwords and sign-on procedures;
- b. Displaying to each FI/Contractor only those potential duplicate claim sets associated with that FI/Contractor;
- c. Displaying HCSR adjustments associated with duplicate institutional claims or duplicate non-institutional line items;
- d. Providing capabilities to track user activities;
- e. Providing system maintenance and data administration capabilities, e.g., automated support for reassigning claim sets upon contractor transitions;
- f. Determining ownership of sets involving potential duplicate claims paid by two different FI/Contractors (i.e., multi-contractor sets). [NOTE: Although the owner designated by the system is the FI/Contractor who paid the latest claim, ownership can be switched to the other contractor involved];
- g. Highlighting claims that appear as potential duplicates in other sets; and
- h. Appending new HCSR claims to existing sets.

