Addendum A Duplicate Claims System Data Fields

DATABASE FIELDS

HCSR DATA ELEMENTS	
FIELD NAME	**DESCRIPTION**
Sponsor SSAN	*Sponsor Social Security Number*
DOB	*Patient Date Of Birth*
DDS	*DEERS Dependent Suffix CODE (DDS)*
PROGIND	*Program Indicator Code*
Provider Tax ID	*Provider Taxpayer Number*
Provider Sub ID	*Multiple Provider ID*
LINEPROC	*Procedure Code*
Diagnosis	*Principle Treatment Diagnosis Code*
DRG	*Diagnosis Related Group Number*
ADMIT	*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*

DATABASE FIELDS (Continued)

HCSR DATA ELEMENTS	
FIELD NAME	**DESCRIPTION**
Type Serv	*Type Of Service*
RECTYPE	*1 = Institutional; 2 = Non-Institutional*
PTC Date	*Processed To Completion Date*
ICN	*Internal Control Number*
SUFFIX	*Control Number Suffix*
Time Stamp	*System time assigned when issuing an initial HCSR*
PROC FI	*HCSR FI Contractor Number*
PROCCONT	*Contract Number*
Batch Sequence #	*Batch Sequence Number*
Voucher Sequence #	*Voucher Sequence Number*
Cycle Number	*TSO Processing Cycle (Year, Month, Cycle Number)*
NAME	*Patient Name*
AGE	*Patient Age*
ENROLLED	*Enrollment Status*
PNTZIP	*Patient Zip Code*
Provider Zip Code	*Provider Zip Code*
Provider Affiliation	*Provider Contract Affiliation Code*
PROVSPEC	*Provider Specialty Code*
TYPE Institution	*Type Of Institution Code*
DISP	*Discharge Disposition*
Govt Pd Amount	*Amount Paid By Government Contractor*

DATABASE FIELDS (Continued)

HCSR DATA ELEMENTS	
FIELD NAME	**DESCRIPTION**
LINENUM	*Claim Line Item Number*
HCSR Line #	*Non-Inst Adjustment Line Item Number; For Inst = 00*
Adjust Date	*Adjustment Date*
Allowed Amount	*Claim Level Adjustment Allowed Amount for Institutional Claim* *Line Item Level Adjustment Allowed Amount for Non-Institutional Claim*
Proced Code	*Non-Inst Procedure Code; Blank For INST*
Care Begin	*Non-Inst Care Begin Date; Blank For INST*

DATABASE FIELDS

GENERATED DATA ELEMENTS	
FIELD NAME	**DESCRIPTION**
CLAIMSET	*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.*
MULTIOWN	*Indicator stating whether claims within the set have been submitted by more than one responsible FI/Contractor.*
COVERED	*In-system, out-of-system, residual indicator for claim.*
RISK	*At -risk, not-at-risk indicator for claim.*
Mass Change Level	*The latest MASS CHANGE cluster rule applied to the claim.*
PNTREG	*Patient health service region code.*
Provider Region	*Provider health service region code.*
PNTAREA	*Patient type of DMIS area: non-catchment = 1, catchment = 2, BRAC = 3.*
PROVAREA	*Provider type of DMIS area: non-catchment = 1, catchment = 2, BRAC = 3.*
Owner FI	*OWNERFI represents, for the claim set, the FI/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 (RESPFI), in which case the OWNERFI 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 OWNERFI is assigned by the system to be the responsible FI/Contractor from the claim within the set having the latest processed-to-completion date.*

DATABASE FIELDS (Continued)

GENERATED DATA ELEMENTS	
FIELD NAME	**DESCRIPTION**
Resp FI	*RESPFI represents, for the claim, the FI/Contractor that is currently responsible for administering the claim. When the claim is initially extracted from HCSR, the RESPFI is identical to the PROCFI (Processing FI). However, contract awarding and transitions may require claim administration by a new FI/Contractor, in which case the system will assign a new RESPFI for the claim.*
Owner Region	*OWNERCONT represents, for the claim set, the owner FI/Contractor contract number. typically, all claims within a set will have the same RESPCONT (responsible contract), in which case the OWNERCONT will be the same as the RESPCONT. However, for multi-contractor or multi-contract claim sets where the FI/Contractors or contract numbers are not the same for all claims within the set, an OWNERCONT is assigned by the system to be the RESPCONT from the claim within the set having the latest processed-to-completion date. The initial assignment is done in tandem with the assignment of OWNERFI.*
Responsible Contract	*RESPCONT represents, for the claim, the contract number under which the claim is currently administered. When the claim is initially extracted from HCSR, the RESPCONT is identical to the PROCCONT (Processing Contract). However, contract awarding and transitions may require claim administration under a new contract, in which case the system will assign a new RESPCONT for the claim.*
Dupe ?	*DUPFLAG is an indicator to describe whether or not the claim is a duplicate. During the extract processes DUPFLAG 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.]* *As the user determines whether claims are duplicates, the DUPFLAG 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.]*

DATABASE FIELDS (Continued)

GENERATED DATA ELEMENTS	
FIELD NAME	**DESCRIPTION**
REASON	*REASON 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 dupeflag being set to "N") a reason code 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 field, NARRATIVE, to be completed for further elaboration.*
HCSR Adjust ?	*ADJFLAG 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 RECOVADJ field is the sum (for the claim) of allowed dollar amounts for those that apply. Display screens enable ADJFLAG to be checked for any institutional claim and any non-institutional line item.*
NARRATE	*NARRATE is a free form text field enabling the user to elaborate on specific reason codes selected for a claim.*
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	*RECOVID 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	*RECOVACT 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.*

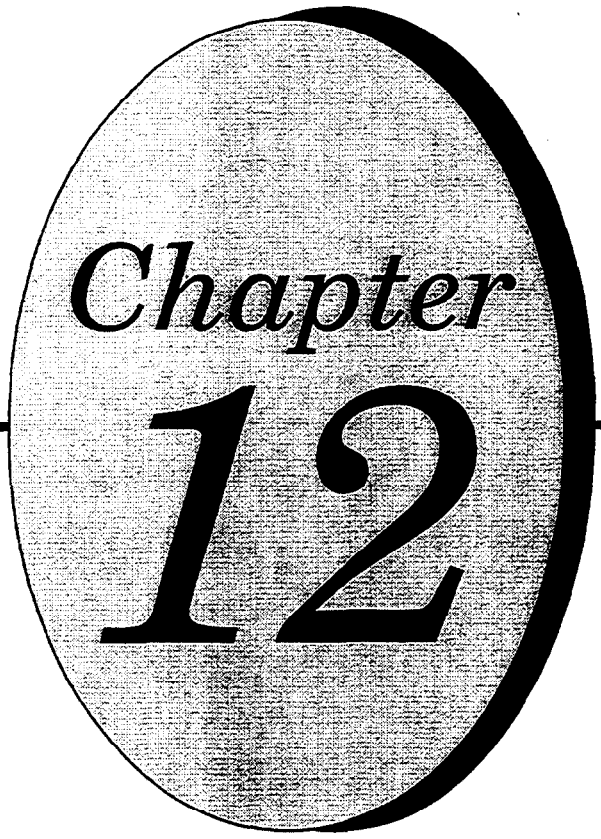
DATABASE FIELDS (Continued)

GENERATED DATA ELEMENTS	
FIELD NAME	**DESCRIPTION**
HCSR Adjustment	*RECOVADJ 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 (ADJALLOW) that have been flagged by the user as being associated with correcting the duplicate. This is the sum of claim header level allowed amounts for institutional claims and line item allowed amounts for non-institutional claims.*
Total Amt Ident Recoup	*TOTRECID is a dollar amount calculated by the system as the sum of RECOVID amounts for all claims within a set. It represents the total amount of overpayment for the claim set that has been identified for recoupment.*
Total Amt Actual Recoup	*TOTRECACT is a dollar amount calculated by the system as the sum of RECOVACT amounts for all claims within a set. It represents the total amount of overpayment for the set that has actually been recouped.*
Total Allowed HCSR Adj	*TOTRECADJ is a dollar amount calculated by the system as the sum of RECOVADJ 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.*
EXPLAIN	*EXPLAIN is a free form text field for user commentary on a claim set. It is required when the user modifies the OWNER FI. It is also required when the user attempts to resolve a set for completion without satisfying all the closing criteria. During recoupment efforts, an FI/Contractor may find that the total actual recoupment amount is different than the total identified amount, or that the (positive-valued) total HCSR adjustment amount is different from the total actual or total identified amounts. At this time, should the user assess that recoupment is sufficient and the claim set can be resolved for completion, the system will present a "pop-up" screen requiring the user to provide an explanation for the discrepancies. The system will assign a status of VALIDATE to these sets.*

DATABASE FIELDS (Continued)

GENERATED DATA ELEMENTS	
FIELD NAME	**DESCRIPTION**
LOADDATE LASTDATE	LOADDATE and LASTDATE are not part of the log record but behave similarly to the LOGDATE field. The LOADDATE 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. The LASTDATE reflects the most recent claim set update date - for specific types of updates.

ADP Manual



Addendum B

Reason Codes

Addendum B Reason Codes

REASON CODE	DESCRIPTION	EXPLANATION	ADDITIONAL EXPLANATION REQUIRED?
ACTUAL DUPLICATE REASON CODES			
Actual duplicate payment was caused as result of:			
D100	*Erroneous dupe edit override.*	*The system identified the Claim as a potential duplicate and suspended it for review. The examiner overrode the duplicate edit error.*	*No*
D101	*Adjustment error.*	*The duplicate payment was a result of an adjustment error - often caused by erroneous duplicate edit override during adjustment adjudication but can be caused by other adjustment processes.*	*Yes*
D102	*Assignment of benefits error - awaiting recoupment/adjustment of erroneous payment.*	*The duplicate payment was a result of the original payment being made to an incorrect payee. The duplicate payment has been made to the correct payee and the recoupment of the erroneous payment has been initiated/received.*	*No*
D200	*System failed to detect and suspend as a potential duplicate.*	*The system did not recognize the claim as a potential duplicate.*	*Yes*
D201	*Data conversion problem.*	*The duplicate payment was a result of data conversion problems. These problems are generally encountered when one or more claims in the set were processed by a previous contractor or a previous system and problems occurred in the conversion of the data by the new contractor/system.*	*No*

REASON CODE	DESCRIPTION	EXPLANATION	ADDITIONAL EXPLANATION REQUIRED?
		ACTUAL DUPLICATE REASON CODES (Continued)	
D202	Claims processed on same day/in same batch.	The duplicate payment was a result of the claim being processed on the same day or in the same batch and not detected by the system duplicate edits.	No
D203	Claims submitted by beneficiary and provider.	The duplicate payment was a result of the system failing to identify duplicate services billed by both the beneficiary and the provider.	No
D204	Claims show different place of service	The duplicate payment was a result of the system failing to identify duplicate services billed on claims showing different place of service codes.	No
D205	Claims show different type of service.	The duplicate payment was a result of the system failing to identify duplicate services billed on claims showing different type of service codes.	No
D206	Claims show different first names.	The duplicate payment was a result of the system failing to identify duplicate services billed on claims showing different patient first names.	No
D207	Multi-suffix claim-suffix contains a duplicate payment.	The duplicate payment was a result of an additional suffix being generated without cancellation(s) of previous suffix(es) being generated or accepted into the TSO data base.	Yes
D208	Paid wrong provider.	The duplicate payment was a result of the initial payment being made to the wrong provider.	No

REASON CODE	DESCRIPTION	EXPLANATION	ADDITIONAL EXPLANATION REQUIRED?
ACTUAL DUPLICATE REASON CODES (Continued)			
D300	Jurisdictional error (multi-contractor set).	The duplicate payment was a result of a jurisdictional error. This claim should have been transferred to and processed by another FI/Contractor.	No
D900	Other		Yes

REASON CODE	DESCRIPTION	EXPLANATION	ADDITIONAL EXPLANATION REQUIRED?
		NON-DUPLICATE REASON CODES	
This claim is not a duplicate because it involves:			
N100	Twins	This is not a duplicate payment since the claim involves a patient who is a twin of the patient on the other claim(s).	No
N101	Ambulance services - separate transport.	This is not a duplicate payment since the claim involves ambulance services for a separate transport from that paid on the other claim(s).	No
N102	Same procedure(s)/service(s) but different encounters (dates of service).	This is not a duplicate payment since the claim involves different dates of service from those paid on the other claim(s).	No
N103	Same condition but different equipment/supplies.	This is not duplicate payment since the claim involves different equipment/supplies than those paid on the other claim(s) for the same condition.	No
N104	Different psychological tests billed under same procedure code(s).	This is not a duplicate payment since the claim involves different psychological tests billed under the same procedure code than those paid on the other claim(s).	No
N105	Additional services not previously billed.	This is not a duplicate payment since the claim involves additional services not paid on the other claim(s).	No
N106	Assistant surgeon/surgeon services.	This is not a duplicate payment since the services paid on this claim are for assistant surgeon services not paid on the other claim(s).	No

REASON CODE	DESCRIPTION	EXPLANATION	ADDITIONAL EXPLANATION REQUIRED?
NON-DUPLICATE REASON CODES (Continued)			
N107	*PFTH prorated DME*	*This is not a duplicate payment since the services paid on this claim are for different PFTH prorated DME than that paid on the other claim(s).*	*No*
N108	*Technical - facility/professional services.*	*This is not duplicate payment since the services paid on this claim involve the technical - facility/professional services not paid on the other claim(s).*	*No*
N109	*Different procedure code modifiers.*	*This is not a duplicate payment since the services paid on this claim have different procedure code modifiers than those on the other claim(s).*	*No*
N110	*Resubmission (Tracer Claim) of previously denied line item(s).*	*This is not a duplicate payment since these services had been previously denied but were resubmitted with corrected procedure codes.*	*No*
N111	*Multi-page claim entered separately.*	*This is not a duplicate payment since this claim contained more than one page which were entered separately as two or more claims.*	*No*
N112	*Multiple services rendered on the same date or within the same date range.*	*This is not a duplicate payment since the multiple services rendered on the same date were legitimate and acceptable or the multiple services billed were rendered on different dates within the date range of the other claim(s).*	*Yes*

REASON CODE	DESCRIPTION	EXPLANATION	ADDITIONAL EXPLANATION REQUIRED?
		NON-DUPLICATE REASON CODES (Continued)	
N113	Incorrect DEERS DEPENDENT SUFFIX	This is not a duplicate payment since the services were rendered to two different patients however the DEERS Dependant Suffix is incorrect creating the appearance of duplicate claims for a single patient.	No
N200	Data conversion errors.	This is not a duplicate payment since the services paid on this claim are different from those paid on the other claim(s), but due to data conversion errors they appear to be the same.	Yes
N201	Multi-suffix claim.	This is not a duplicate payment since the services paid on this claim suffix are different from those paid on the other suffix(es). NOTE: To use this reason code, the additional suffix listed cannot contain any payments contained in a previous suffix. If the additional suffix was issues to pay a different provider, or it reflects a payment issues under a previous suffix and a cancellation of the previous suffix has been issues or will be issued for the previous suffix, it is still a duplicate payment and the claim should be assigned "Y" Dupe Flag and an "Actual Duplicate Reason Code" used.	Yes
N900	Other		Yes