OVERVIEW

NOTE: *The TRICARE Management Activity (TMA) has developed a web-based version of* the TRICARE Duplicate Claims System *(DCS)* that runs on the Internet/*Nonsecure Internet Protocol Router Network (*NIPRNET*)*. The functionality of the web version *mimics the functionality of* the *prior* client/server *(C/S) version as closely as possible*. Differences will be in the telecommunications specifications *and methods for requesting and accessing/displaying reports and data downloads*. Please refer to the TRICARE Systems Manual *(TSM)*, Chapter 1, for information on connecting to the NIPRNET. The extract criteria used for identifying potential duplicate claim sets *and t*he rules for operating the system and resolving duplicate claim sets are the same *in the web version as they were in* the *C/S* version. The *web version* will be accessed via a web browser (*Microsoft®* Internet Explorer *(MSIE), Version* 5.5*, 6.0,* or *7.0 or as directed by the Government*). *This differs from the C/S version which accesses the data via the Business-To-Business (B2B) Gateway. This manual explains the functions and shows examples of screens and reports in the web format.*

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

The TRICARE DCS was developed by the TRICARE Management Activity (TMA) 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.

1.0. 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. In the interests of space and readability, this document uses the word contractor or the term "FI" (or contractors or FIs for the plural) to mean TRICARE Managed Care Support Contractor *(MCSC)/TRICARE Dual Eligible Fiscal Intermediary Contractor (TDEFIC)* 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 THE SET** button). All field names are shown in upper*case* and lowercase letters and bold type (e.g., **Dupe?** field). All claim set status categories are represented in upper*case* and lowercase with italics (e.g., *Open* status). Menu Bar selections are shown with a letter underlined and in bold, just as they

appear on the screen (e.g., **V**iew 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: total amount identified for recoupment in field **ID Recoup**; total amount actually recouped in field **Actual Recoup**; and total HCSR adjustment allowed in field **Adjust Amount**.

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 initial system installation.

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 *DCS* is the property of the United States Government.

2.0. 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 *DCS*, when two or more payments are issued for the same service for the same beneficiary, the additional payments are considered actual duplicate payments, regardless of whether the additional payments were justified or made in error, recoupment of the additional payments initiated, or refunds *already* 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 *DCS*. The same process and logic is applicable for duplicate suffixes. It must be noted that claims data displayed in the *DCS* are HCSR records. The Government assumes that the HCSR records submitted by contractors accurately reflect the adjudication of the claims and the dollars paid. When a user works in the *DCS*, they are seeing records that reside on the HCSR database. They are seeing what appears to the Government to be duplicate payments. Users might think of HCSR records as entries in the Government's checkbook. When a pair of HCSR records are displayed in the *DCS*, they are, in essence, representing two entries in the Government's checkbook. If these entries are not cancelled or adjusted, they represent actual dollars spent. For the purposes of the *DCS*, an unadjusted or non-cancelled HCSR record on the HCSR database represents a claims payment even if the claim appears on the contractor's claims processing system as having been adjusted or cancelled. All duplicate HCSR records displayed in the DCS must be

flagged as actual duplicate payments and must be corrected through adjustments and cancellations to remove the duplicate conditions from the HCSR database.

3.0. DEVELOPMENT OF THE SYSTEM

The *DCS* 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 duplicate conditions in the HCSR database. The system was designed to optimize the efforts of both TMA staff and contractor staff in meeting their respective responsibilities regarding duplicate claim payments.

3.1. TMA And Contractor Benefits

For the TMA, the system provides the tools to ensure that potential and actual duplicate payments are identified, recoupments are received, HCSR database corrections are made, and contractor standards of performance are met. For 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, *pre*-formatted reports are included in the *DCS* to help analyze trends, contractor performance, and processing or procedural problems in contractor operations.

3.2. System Objectives

The system was designed to meet the following objectives:

3.2.1. To create a user-friendly, cost-effective application using *web-based* technology;

3.2.2. To preserve HCSR data integrity and display only those potential duplicate claims records applicable to each contractor;

3.2.3. To provide as much data as possible to assist contractors in their efforts to identify actual duplicate payments;

3.2.4. 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;

3.2.5. To automate methods for grouping and displaying institutional and non-institutional potential duplicate HCSRs to contractors for research and resolution;

3.2.6. To automate and simplify methods for 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;

3.2.7. To automate and simplify methods for 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;

3.2.8. To automate methods to facilitate TMA and contractor audits and performance monitoring and;

3.2.9. To provide the capability to generate user defined reports and graphs.

In meeting these objectives, the system provides the tools to monitor timely contractor research and accurate identification of actual duplicate payments and aids in diagnosing processing problems *that* cause duplicate payments.

4.0. FUNCTIONAL CAPABILITIES OF THE *DCS*

The *DCS* is an on-line, *real-time,* user-friendly system. The *DCS* employs five different HCSR-based, duplicate detection match criteria to identify potential duplicate claims. It also accommodates contractor transitions, financially underwritten/non-financially underwritten claims, and duplicate claims payments caused by jurisdictional processing errors. The *DCS* improves TMA and 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. The functional capabilities of the *DCS* supports the claims resolution process.

4.1. The Claims Resolution Process

The process by which duplicate claims are corrected in the *DCS* is referred to as the "claims resolution process". To initiate the claims resolution process, the *DCS* identifies and groups potential duplicate claims into "sets". This enables 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 contractor will identify the duplicate payment by entering a 'Y' (for "Yes") in the **Dupe?** field of that claim. If there are only two claims in the set, the other claim will have a 'N' (for "No") in the **Dupe?** field to indicate it was the original or BASE claim. Only one claim in a set can be the BASE claim. The claims resolution process requires a 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 contractor will enter the amount actually recouped.

After recording the amount actually recouped for the duplicate claim, the 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 DCS for processing. This processing, which generally occurs daily, adds adjustment transactions to appropriate sets. When the appropriate adjustment appears in a set, the contractor can verify removal of the duplicate condition from the HCSR database by flagging the adjustment transaction (i.e., by entering 'Y' in the **HCSR Adjust?** field of the claim). All claims identified as a duplicate payment must have a 'Y' in the **Dupe?** 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 can now be resolved by clicking the **RESOLVE THE SET** button which invokes the "rules of resolution". (See *Section 4, Figure 9-4-1.*) 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.

4.2. Extracting HCSR Data To Create And Maintain The Duplicate Claims Databases

Using the duplicate claims detection criteria, the *DCS* identifies potential duplicate claims from HCSRs residing in the HCSR database. These claims are extracted from the HCSR database. At the same time, data elements and values required for system operation are added and the records are loaded to a TMA *DB2®* Server. HCSR records are then converted and imported into tables. These tables comprise the Duplicate Claims *d*atabases. HCSR data and *DCS* data residing in the Duplicate Claims *d*atabases are accessible to users through the *DCS* application. See *Section 3, paragraph 1.0.* for details on the building of the Duplicate Claims *d*atabases.

5.0. SYSTEM DESIGN

In technical terms, the *DCS* is a "*web-based*" application. This term is used to describe an automated system that provides a user-friendly "*web browser*" environment on distributed personal computers *(PCs) that* interface with a transaction-based "server" environment that processes transactions, maintains databases, and optimizes the access and transfer of data between the two environments.

5.1. System Platforms

The *DCS* utilizes *two* platforms:

5.1.1. *DB2* Server Platform

The DCS system resides on an IBM RS6000 Regatta P Series System. The operating system is Advanced IBM Unix (AIX). The database management system is IBM DB2, utilizing DB2 tables (i.e., the Duplicate Claims databases).

5.1.2. PC Platform

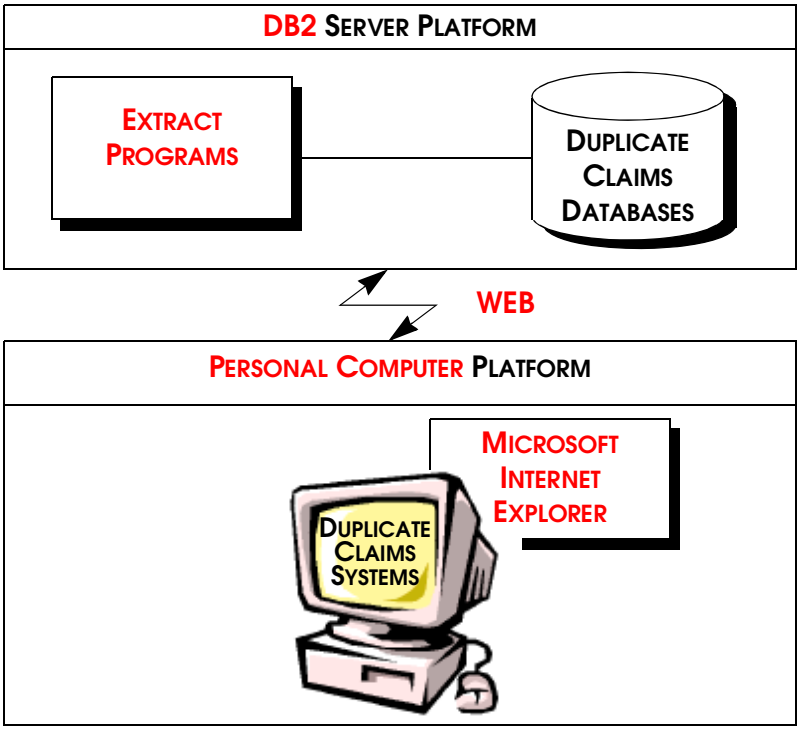
The PC platform is composed of *PCs using MSIE, Version 5.5, 6.0, or 7.0 or as directed by the Government*. *These PCs may be stand-alone or networked computers. The PCs must have Internet access.*

User screens include ease-of-use features such as tabs, 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.

5.2. Communications

The *two* system platforms described above and shown in Figure 9-1-1, operate independently. Data is transmitted from one platform to another through interfaces and a communications network. Users connect to this network and the *DCS* via *contractor*-supplied *web* communication*s*. Instructions on establishing a connection to the network and the *DCS* will be provided by the Government.

FIGURE 9-1-1 SYSTEM PLATFORMS



5.3. Design Efficiencies

To optimize system resources, the *DCS* 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.

5.3.1. 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 *C*laim *S*et *N*umber, *S*ponsor Social Security Account Number (SSAN), or *Internal Control N*umber (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.

5.3.2. Background Mode

The background processing mode contains system functionality for system administration and maintenance, such as the interface with the HCSR data on the *DB2 Server* 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 contractor accesses only their own data.

6.0. SYSTEM FUNCTIONS

The *DCS* provides a broad range of user functions to support contractor and TMA activities and to ensure system integrity.

6.1. Claim Set Resolution Functions

As specified in all MCS contracts, contractors are responsible for both preventing and resolving duplicate claim payments. The *DCS* supports contractors in this responsibility by automating the *resolution* 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 duplicate conditions.

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

6.1.1. Enter a 'Y' or 'N' to indicate that a claim does or does not represent an actual duplicate payment;

6.1.2. Select a reason code from a pre-defined list of reason codes for each claim, and enter a narrative description when prompted to explain why a claim does or does not represent an actual duplicate payment;

6.1.3. Enter the dollar amount identified for recoupment for each actual duplicate claim;

6.1.4. Enter the dollar amount actually received from the recoupment/offset action of each duplicate claim; and

6.1.5. Submit the HCSR adjustment and link this adjustment to the actual duplicate claim after the adjustment has been processed by the HCSR system and *loaded to* the *DCS*.

6.2. 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:

6.2.1. Verifying user authorization through passwords and sign-on procedures;

6.2.2. Displaying to each contractor only those potential duplicate claim sets associated with that contractor;

6.2.3. Displaying HCSR adjustments associated with duplicate institutional claims or duplicate non-institutional line items;

6.2.4. Providing capabilities to track user activities;

6.2.5. Providing system maintenance and data administration capabilities, e.g., automated support for reassigning claim sets upon contractor transitions;

6.2.6. Determining ownership of sets involving potential duplicate claims paid by two different contractors (i.e., multi-contractor sets). [NOTE: Although the owner designated by the system is the contractor who paid the latest claim, ownership can be switched to other contractors involved];

6.2.7. Highlighting claims that appear as potential duplicates in other sets; and

6.2.8. Appending new HCSR claims to existing sets.