

## 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 10-3-1*, shows the specific TED data field match criteria used to select potential institutional duplicate claims.

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

**FIGURE 10-3-1 DATA FIELD MATCH CRITERIA FOR INSTITUTIONAL CLAIMS *PRIOR TO THE NPI IMPLEMENTATION***

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

\* 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 NPI Implementation**

*The following categories of match criteria are used to identify and link two or more matched institutional claims. Figure 10-3-2, 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 10-3-2 DATA FIELD MATCH CRITERIA FOR INSTITUTIONAL CLAIMS ON OR AFTER THE NPI IMPLEMENTATION**

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

\* 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 10-3-3*, 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 10-3-3 DATA FIELD MATCH CRITERIA FOR NON-INSTITUTIONAL CLAIMS**

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

\* 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 10-3-4, 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.

TRICARE OPERATIONS MANUAL 6010.51-M, AUGUST 1, 2002

CHAPTER 10, SECTION 3

DUPLICATE CLAIMS DATA

**FIGURE 10-3-4 DATA FIELD MATCH CRITERIA FOR NON-INSTITUTIONAL CLAIMS ON OR AFTER NPI IMPLEMENTATION**

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

\* 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).

**TRICARE OPERATIONS MANUAL 6010.51-M, AUGUST 1, 2002**

CHAPTER 10, SECTION 3

DUPLICATE CLAIMS DATA

**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 <sup>1</sup>	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

<sup>1</sup> CPT only © 2006 American Medical Association (or such other date of publication of CPT). All Rights Reserved.

**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.)

### **2.5.4. Provisional Claim Sets**

**2.5.4.1.** *With the implementation of TEDs, a new concept was introduced, namely the Provisional TED. A provisional TED (claim) is a TED that passed transmission and validity edits but failed one or more relational edits. TEDs that fail relational edits are accepted into the TED database provisionally and are required to be corrected within 30 days. Since they are accepted in the TED database, they are included in the DCS extracts. Since a provisional TED, by definition, will be corrected by the contractor, any provisional TEDs that are included in a DCS set, could be corrected in a manner that might remove it as a potential duplicate. As a result, the DCS flags each provisional TED that is included in a set at the claim level and flags the set as provisional as well. Provisional sets (sets in*

*which one or more TEDs (claims) are provisional) are shaded red and users are prevented from working those sets.*

**2.5.4.2.** *When an adjustment is submitted that corrects the provisional condition of the original TED, the DCS will change the affected TED in the set to non-provisional, verify that no other provisional TEDs reside in the set, and change the set from provisional to a normal DCS set that users can work.*