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TRICARE
MANAGEMENT ACTIVITY

PCPB

CHANGE 65
6010.51-M
MAY 1, 2008

PUBLICATIONS SYSTEM CHANGE TRANSMITTAL FOR TRICARE OPERATIONS MANUAL (TOM)

The TRICARE Management Activity has authorized the following addition(s)/ revision(s) to 6010.51-M, reissued August 2002.

CHANGE TITLE: **AMA LICENSE AGREEMENT UPDATE**

PAGE CHANGE(S): See page 2.

SUMMARY OF CHANGE(S): This change updates the footnote for the AMA License Agreement for 2006 and future publications.

EFFECTIVE AND IMPLEMENTATION DATE: Upon direction of the Contracting Officer.

This change is made in conjunction with Aug 2002 TPM, Change No. 78, Aug 2002 TRM, Change No. 77, and Aug 2002 TSM, Change No. 60.

Laura Sells
Chief, Purchased Care Procurement Branch

ATTACHMENT(S): 21 PAGES
DISTRIBUTION: 6010.51-M

WHEN PRESCRIBED ACTION HAS BEEN TAKEN, FILE THIS TRANSMITTAL WITH BASIC DOCUMENT

REMOVE PAGE(S)	INSERT PAGE(S)
CHAPTER 9	
Section 3, pages 5 through 7	Section 3, pages 5 through 7
Addendum E, pages 27, 28, 41, 42, and 49 through 52	Addendum E, pages 27, 28, 41, 42, and 49 through 52
CHAPTER 10	
Section 3, pages 5 and 6	Section 3, pages 5 and 6
Addendum E, pages 27, 28, 41, 42, and 49 through 52	Addendum E, pages 27, 28, 41, 42, and 49 through 52

FIGURE 9-3-2 DATA FIELD MATCH CRITERIA FOR NON-INSTITUTIONAL CLAIMS

FIELD NAME	OTHER	CPT-4 CODE	NEAR MATCH	EXACT MATCH
CLAIM LEVEL				
SPONSOR SSAN	✔	✔	✔	✔
DEERS DEPN SUFFIX	✔	✔	✔	✔
PATIENT DOB				✔
PROGRAM INDICATOR				✔
PROVIDER TAX ID	✔	✔	✔	✔
PROVIDER SUB ID	✔	✔	✔	✔
PRIN DIAGNOSIS				✔
LINE ITEM LEVEL				
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.

2.3. Exclusions

2.3.1. Exclusion Of Certain Claims

The Duplicate Claims System excludes claims from the extract if they do not meet specific minimum dollar thresholds and other criteria. An individual claim is excluded if:

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

2.3.1.2. The total allowed amount is less than $30.00.

2.3.1.3. The claim's program indicator is 'D' (Drug).

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

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

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

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

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

2.3.2. Exclusion Of Certain Line Items

The Duplicate Claims System 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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2.3.3. 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:

2.3.3.1. 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.

2.3.3.2. 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.)

2.3.3.3. The set is a "Pseudo" DEERS Dependent Suffix (DDS) claim set and contains no more than two claims, where the DDS on both claims is '75' and the names on the claims are not the same.

2.3.3.4. 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.)

2.3.3.5. The set contains no more than two line items and each have a 99283 CPT[1] procedure code and the program indicator is an 'I' on one claim and a 'N' on the other.

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REPORT CATEGORY:	Claim Report
REPORT MENU HIERARCHY AND FORMAT NAME:	REPORT ⇒CLAIM REPORTS ⇒NON-INSTITUTIONAL ⇒**BY LINE ITEM**
PRINTED REPORT TITLE:	Non-Institutional Claims By Line Item
REPORT DESCRIPTION:	This report lists non-institutional claims grouped by current set status. This report displays line-item data. The fields displayed on the report are: Owner FI; Region; Set Status Code; ICN; HCSR Suffix; Claim Level User Defined Code; Solicited Indicator; Set Number; Responsible FI; Sponsor Social Security Number; Patient Name; DEERS Dependent Suffix; Provider Tax ID; Provider Sub-ID; Line Item Number; CPT-4 Code; Care Begin Date; Care End Date; and Amount Allowed CPT-4 Code. The report identifies and prints all of the sets meeting the criteria selected on the report parameter screen. The report groups the claims in ascending set number order.
REPORT PARAMETER OPTIONS:	Users may customize the report by selecting: All "Standard" parameters minus Claim Type (Claim Set Status, Adjustments, Set Owner Type, Match Type, Date Type, Set Range, FI, Region) plus Dupe Flag Indicator, Solicited Indicator, Exclude Base, PTC Date; Care Dates; Set Level User Defined Codes; Claim Level User Defined Codes; Responsible FI; and Region.
REPORT NOTES:	The data used by this report format is line item level data. The allowed amounts are line item level dollar amounts.

03/09/2002 **NON-INSTITUTIONAL CLAIMS BY LINE ITEM** Page 1

Status Codes = ALL
Adjusted Type = ALL
Set Owner Type = ALL
Claim Type = ALL
Match Type = ALL
FI Code = ALL
Region Code = ALL
Dupe Flag = ALL
Exclude Base = No
Solicited = ALL
Set Range = >=500,<=600
Set User Code = ALL
Claim User Code = ALL

Region
Status Code : C

ICN	SFX	USR CD	S ?	SET #	RESP FI	SPON SSAN	PATIENT NAME	DDS	PROVIDER TAX ID	PROV SUB-ID	LI	CPT-4 CODE[1]	CARE BEGIN	CARE END	AMT ALLOWED CPT-4 CODE
19942491246269	A			549				01		A008	1	90830	08/24/94	08/24/94	$199.35
19942691244498	A			549				01		A008	1	90830	08/24/94	08/24/94	$132.90
19942561211458	A			563				30		0000	1	06902	04/15/94	04/15/94	$42.00
19942691202556	A			563				30		0000	1	06902	04/15/94	04/15/94	$42.00
19923562212301	A			576				02		H286	1	88304	11/18/92	11/18/92	$27.20
19923562212301	A			576				02		H286	2	88304	11/18/92	11/18/92	$27.20
19942762276579	A			576				02		H286	1	88304	11/18/92	11/18/92	$44.70
19942762276579	A			576				02		H286	2	88304	11/18/92	11/18/92	$44.70
19942762276579	A			576				02		H286	3	88304	11/18/92	11/18/92	$44.70
19942161211118	A			583				30		A002	8	96545	07/01/94	07/01/94	$758.00
19942301211640	A			583				30		A002	6	96545	07/01/94	07/20/94	$670.00
19942621211159	A			583				30		A002	2	96545	07/01/94	07/01/94	$376.00
19941611203636	A			584				30		A009	1	99233	08/01/93	08/01/93	$70.72
19942901200432	A			584				30		A009	2	99233	08/01/93	08/01/93	$70.72
													Status Totals		$2,550.19

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03/09/2002

Page 1

PROVIDER CPT-4 REPORT

GROUPED BY PROVIDER TAX ID AND SUB ID
(CPT-4 CLAIM LEVEL MATCH TYPES ONLY)

Status Codes = ALL
Adjusted Type = ALL
Set Owner Type = ALL
Claim Type = ALL
Match Type' = ALL
FI Code =
Region Code = ALL
Actual Dupes Only = No
Exclude Base = ALL
Solicited = ALL
Claim User Code = ALL

ICN	TIME	SFX	USR CD	S ?	SET #	DUP FLG	SPON SSAN	PATIENT NAME	DDS	LI MATCH	LINE ITEM #	CPT-4 CODE[1]	AMT ALLOWED CPT-4 CODE	PTC DATE	RESP FI
Tax ID:															
Sub ID: **0001**															
19991443312368	413957	A			163810	N			02	C	2	99282	$75.00	05/28/99	06
19991653313204	521965	A			163810	Y			02	C	2	99283	$75.00	06/18/99	06
								# Line Items					**Allowed $**		
								Sub ID Totals		**2**			**$150.00**		
								Prov ID Totals		**2**			**$150.00**		
Tax ID:															
Sub ID: **A002**															
20011492546319	285262	B			248566	N			30	C	2	93555	$180.00	06/05/01	06
20011492549773	214907	A			248566	N			30	C	1	93556	$180.00	06/05/01	06
								# Line Items					**Allowed $**		
								Sub ID Totals		**2**			**$360.00**		
								Prov ID Totals		**2**			**$360.00**		
Tax ID:															
Sub ID: **0000**															
20002132551521	291356	A			215290	N			30	O	2	83891	$10.01	08/03/00	06
20002132551521	291356	A			215290	N			30	O	3	83898	$28.85	08/03/00	06
20002132551521	291356	A			215290	N			30	O	5	83912	$29.40	08/03/00	06
20002272545854	114374	A			215290	N			30	O	1	83891	$10.01	08/17/00	06
20002272545854	114374	A			215290	N			30	O	2	83891	$10.01	08/17/00	06
20002272545854	114374	A			215290	N			30	C	3	83892	$12.01	08/17/00	06
20002272545854	114374	A			215290	N			30	C	4	83892	$12.01	08/17/00	06
20002272545854	114374	A			215290	N			30	C	5	83894	$8.49	08/17/00	06
20002272545854	114374	A			215290	N			30	C	6	83894	$8.49	08/17/00	06

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REPORT CATEGORY:	Claim Report
REPORT MENU HIERARCHY AND FORMAT NAME:	REPORT ⇒CLAIM REPORTS ⇒REASON CODE EXPLANATION ⇒**INDIVIDUAL CLAIMS**
PRINTED REPORT TITLE:	Reason Code Explanation Report Individual Claims
REPORT DESCRIPTION:	This report provides a listing of the explanations associated with reason codes on individual claims. The Duplicate Claims System requires that an explanation be entered when certain reason codes are used to describe why a claim is or is not a duplicate claim. This report prints the reason code explanation associated with a claim. Individual claim data is grouped within their respective sets. The fields displayed on this report are: Owner FI; Region; Set Number; Set Status; Initial Load Date; ICN; HCSR Suffix; HCSR Time Stamp; Responsible FI; PTC Date; Dupe Flag Indicator; Reason Code; and Reason Code Explanation.
REPORT PARAMETER OPTIONS:	Users may customize the report by selecting: All "Standard" parameters (Claim Set Status, Adjustments, Set Owner Type, Claim Type, Match Type, Date Type, Set Range, FI, Region) plus Responsible FI, Region, and Reason Codes.
REPORT NOTES:	The data used by this report format is claim level data.

03/09/2002 **INSTITUTIONAL CLAIMS WORKSHEET** Page 1

Status Codes = ALL
Adjusted Type = ALL
Set Owner Type = ALL
Claim Type = ALL
Match Type = ALL
FI Code = ALL
Region Code = ALL
Set Range = >=1,<=100
Solicited = ALL

Region

ICN	S FX	USR	S ?	SET #	PTC DATE	RE FI	SPON SSAN	PATIENT NAME	DDS	PROVIDER TAX ID	PROV SUB-ID	DIAG[1]	DRG	AMT BILLED	AMT ALLOWED	NET GOVT PAID AMT	DUPE? (Y/N)	RSN CD	RECOUP/ RFND AMT
9942291298092	A			17	08/18/94				01		0000	29633	000	$554.00	$320.00	$272.00	-----	-----	---------
9942311298375	A			17	10/03/94				01		0000	29633	000	$8,038.00	$4,480.00	$3,808.00	-----	-----	---------
9942434706972	A			58	10/20/94				01		0000	311	000	$40,677.28	$8,404.00	$8,404.00	-----	-----	---------
9942454797399	A			58	09/12/94				01		0000	29620	000	$4,433.54	$3,438.00	$3,438.00	-----	-----	---------
9941121298252	A			94	10/13/94				02		0001	31381	000	$1,045.27	$510.00	$510.00	-----	-----	---------
9942341216190	A			94	09/01/94				01		0001	31381	000	$14,482.23	$11,280.00	$6,953.86	-----	-----	---------

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REPORT CATEGORY:	Claim Report
REPORT MENU HIERARCHY AND FORMAT NAME:	REPORT ⇒CLAIMS ⇒WORKSHEETS ⇒**NON-INSTITUTIONAL**
PRINTED REPORT TITLE:	Non-Institutional Claims Worksheet
REPORT DESCRIPTION:	This report resembles the paper duplicate claims reports provided to contractors in the past. This report lists the sets of non-institutional line items in OPEN status and provides space for entering by hand: 1) a "Y" or an "N" to indicate if the claim has been determined to be a duplicate or not; 2) a reason code for why the claim is or is not a duplicate; and 3) a recoupment or refund amount. This report provides the contractor with the ability to distribute the claim sets requiring research and duplicate determinations among several personnel. Once completed, these reports can be returned to the system operator for data entry. This report is limited to only non-institutional claims. The fields displayed on the report are: Owner FI; Region; ICN; HCSR Suffix; Claim Level User Defined Code; Solicited Indicator; Set Number; Responsible FI; Sponsor SSAN; Patient Name; DEERS Dependent Suffix; Provider Tax ID; Provider Sub-ID; Diagnosis; Line Item Number; CPT-4 Code; Line Item Amount Billed; Line Item Allowed Amount; "Dupe? (Y/N)"; Reason Code; and Identified Recoupment or Refund Amount. The report identifies and prints all of the sets meeting the criteria selected on the report parameter screen. The report groups the claims in ascending set number order.
REPORT PARAMETER OPTIONS:	Users may customize the report by selecting: All "Standard" parameters minus Status, Claim Type (Adjustments, Set Owner Type, Match Type, Date Type, Set Range, FI, Region) plus Dupe Flag Indicator, PTC Dates, Responsible FI, and Region.
REPORT NOTES:	The data used by this report format is line item level data.

03/09/2002 **NON-INSTITUTIONAL CLAIMS WORKSHEET** Page 1

Status Codes = ALL
Adjusted Type = ALL
Set Owner Type = ALL
Claim Type = ALL
Match Type = ALL
FI Code = ALL
Region Code = ALL
Set Range = >=500,<=800
Solicited = ALL

99 -

Inactive -

ICN	S FX	USR CD	S ?	SET #	RESP FI	SPON SSAN	PATIENT NAME	DDS	PROVIDER TAX ID	PROV SUB-ID	DIAG[1]	LI	CPT-4 CODE[1]	AMT BILLED CPT-4 CD	AMT ALD CPT-4 CD	DUPE? (Y/N)	RSN CD	RECOUP/ RFND AMT
19942450610144	B			546	99			03		A033	31400	1	90844	$280.00	$216.80	-----	-----	---------
19942510640309	B			546	99			03		A033	30723	1	90844	$560.00	$433.60	-----	-----	---------
19940830610180	A			547	99			03		A033	31400	3	90844	$280.00	$216.80	-----	-----	---------
19942510640309	B			547	99			03		A033	30723	4	90844	$840.00	$650.40	-----	-----	---------
19940940616755	A			548	99			03		A033	30723	1	99232	$90.00	$61.40	-----	-----	---------
19942510640309	B			548	99			03		A033	30723	7	99232	$90.00	$61.40	-----	-----	---------
19941740613080	A			566	99			03		0000	27700	3	06879	$65.00	$65.00	-----	-----	---------
19941740613080	A			566	99			03		0000	27700	4	06877	$97.25	$88.41	-----	-----	---------
19941820615030	A			566	99			03		0000	27700	1	06870	$65.00	$65.00	-----	-----	---------
19941820615030	A			566	99			03		0000	27700	2	06876	$97.25	$97.25	-----	-----	---------

Inactive - CA/HI 88C

ICN	S FX	USR CD	S ?	SET #	RESP FI	SPON SSAN	PATIENT NAME	DDS	PROVIDER TAX ID	PROV SUB-ID	DIAG[1]	LI	CPT-4 CODE[1]	AMT BILLED CPT-4 CD	AMT ALD CPT-4 CD	DUPE? (Y/N)	RSN CD	RECOUP/ RFND AMT
19941920640028	A			531	99			30		0000	4111	1	33533	$2,100.00	$490.70	-----	-----	---------
19941920640028	A			531	99			30		0000	4111	2	36489	$240.00	$240.00	-----	-----	---------
19941920640028	A			531	99			30		0000	4111	3	36620	$180.00	$180.00	-----	-----	---------
19941920640028	B			531	99			30		0000	4111	1	33533	$2,100.00	$2,100.00	-----	-----	---------
19941920640028	B			531	99			30		0000	4111	2	36489	$240.00	$240.00	-----	-----	---------
19941920640028	B			531	99			30		0000	4111	3	36620	$180.00	$180.00	-----	-----	---------

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REPORT CATEGORY:	Claim Report
REPORT MENU HIERARCHY AND FORMAT NAME:	REPORT ⇒CLAIM REPORTS ⇒**CLAIM LEVEL USER CODES**
PRINTED REPORT TITLE:	Claim Level User Defined Field Definitions
REPORT DESCRIPTION:	This report displays the Owner FI; Contract Number; the Claim Level User Defined Codes; their definitions, and whether they are active or inactive.
REPORT PARAMETER OPTIONS:	Users may not customize this report.
REPORT NOTES:	The data used by this report format is claim level data.

FIGURE 10-3-2 DATA FIELD MATCH CRITERIA FOR NON-INSTITUTIONAL CLAIMS

FIELD NAME	OTHER	CPT-4 CODE	NEAR MATCH	EXACT MATCH
CLAIM LEVEL				
SPONSOR SSAN	✔	✔	✔	✔
PATIENT ID	✔	✔	✔	✔
PATIENT DOB				✔
PROVIDER TAX ID	✔	✔	✔	✔
PROVIDER SUB ID	✔	✔	✔	✔
PRIN DIAGNOSIS				✔
LINE ITEM LEVEL				
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.

2.3. Exclusions

2.3.1. Exclusion Of Certain Claims

The Duplicate Claims System excludes claims from the extract if they do not meet specific minimum dollar thresholds and other criteria. An individual claim is excluded if:

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

2.3.1.2. The total allowed amount is less than $30.00.

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

2.3.1.4. 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).

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

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

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

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

2.3.2. Exclusion Of Certain Line Items

2.3.2.1. Prior to the implementation of the Outpatient Prospective Payment System (OPPS), the Duplicate Claims System (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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2.3.2.2. Upon implementation of OPPS, the DCS excludes line items from the extract if the line item procedure code (HCPCS or CPT-4) is listed in paragraph 2.3.2.1. or in the TRICARE Systems Manual (TSM), Chapter 2, Addendum O.

REPORT CATEGORY:	Claim Report
REPORT MENU HIERARCHY AND FORMAT NAME:	REPORT ⇒CLAIM REPORTS ⇒NON-INSTITUTIONAL ⇒**BY LINE ITEM**
PRINTED REPORT TITLE:	Non-Institutional Claims By Line Item
REPORT DESCRIPTION:	This report lists non-institutional claims grouped by current set status. This report displays line-item data. The fields displayed on the report are: Owner FI; Region; Set Status Code; ICN; Claim Level User Defined Code; Solicited Indicator; Set Number; Responsible FI; Sponsor Social Security Number; Patient Name; Provider Tax ID; Provider Sub-ID; Line Item Number; CPT-4 Code; Care Begin Date; Care End Date; and Amount Paid CPT-4 Code. The report identifies and prints all of the sets meeting the criteria selected on the report parameter screen. The report groups the claims in ascending set number order.
REPORT PARAMETER OPTIONS:	Users may customize the report by selecting: All "Standard" parameters minus Claim Type (Claim Set Status, Adjustments, Set Owner Type, Match Type, Date Type, Set Range, FI, Region) plus Dupe Flag Indicator, Solicited Indicator, Exclude Base, PTC Date; Care Dates; Set Level User Defined Codes; Claim Level User Defined Codes; Responsible FI; and Region.
REPORT NOTES:	The data used by this report format is line item level data. The paid amounts are line item level dollar amounts.

03/09/2002 **NON-INSTITUTIONAL CLAIMS BY LINE ITEM** Page 1

Status Codes = ALL
Adjusted Type = ALL
Set Owner Type = ALL
Claim Type = ALL
Match Type = ALL
FI Code = ALL
Region Code = ALL
Dupe Flag = ALL
Exclude Base = No
Solicited = ALL
Set Range = >=500,<=600
Set User Code = ALL
Claim User Code = ALL

Region
Status Code : C

ICN	SFX	USR CD	S ?	SET #	RESP FI	SPON SSAN	PATIENT NAME	PROVIDER TAX ID	PROV SUB-ID	LI	CPT-4 CODE[1]	CARE BEGIN	CARE END	AMT PAID CPT-4 CODE
19942491246269	A			549					A008	1	90830	08/24/94	08/24/94	$199.35
19942691244498	A			549					A008	1	90830	08/24/94	08/24/94	$132.90
19942561211458	A			563					0000	1	06902	04/15/94	04/15/94	$42.00
19942691202556	A			563					0000	1	06902	04/15/94	04/15/94	$42.00
19923562212301	A			576					H286	1	88304	11/18/92	11/18/92	$27.20
19923562212301	A			576					H286	2	88304	11/18/92	11/18/92	$27.20
19942762276579	A			576					H286	1	88304	11/18/92	11/18/92	$44.70
19942762276579	A			576					H286	2	88304	11/18/92	11/18/92	$44.70
19942762276579	A			576					H286	3	88304	11/18/92	11/18/92	$44.70
19942161211118	A			583					A002	8	96545	07/01/94	07/01/94	$758.00
19942301211640	A			583					A002	6	96545	07/01/94	07/20/94	$670.00
19942621211159	A			583					A002	2	96545	07/01/94	07/01/94	$376.00
19941611203636	A			584					A009	1	99233	08/01/93	08/01/93	$70.72
19942901200432	A			584					A009	2	99233	08/01/93	08/01/93	$70.72
												Status Totals		$2,550.19

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PROVIDER CPT-4 REPORT

GROUPED BY PROVIDER TAX ID AND SUB ID
(CPT-4 CLAIM LEVEL MATCH TYPES ONLY)

Status Codes = ALL
Adjusted Type = ALL
Set Owner Type = ALL
Claim Type = ALL
Match Type' = ALL
FI Code =
Region Code = ALL
Actual Dupes Only = No
Exclude Base = ALL
Solicited = ALL
Claim User Code = ALL

ICN	TIME	SFX	USR CD	S ?	SET #	DUP FLG	SPON SSAN	PATIENT NAME	LI MATCH	LINE ITEM #	CPT-4 CODE[1]	AMT PAID CPT-4 CODE	PTC DATE	RESP FI
Tax ID: Sub ID: **0001**														
19991443312368	413957	A			163810	N			C	2	99282	$75.00	05/28/99	06
19991653313204	521965	A			163810	Y			C	2	99283	$75.00	06/18/99	06
								# Line Items				**Paid $**		
								Sub ID Totals	**2**			**$150.00**		
								Prov ID Totals	**2**			**$150.00**		
Tax ID: Sub ID: **A002**														
20011492546319	285262	B			248566	N			C	2	93555	$180.00	06/05/01	06
20011492549773	214907	A			248566	N			C	1	93556	$180.00	06/05/01	06
								# Line Items				**Paid $**		
								Sub ID Totals	**2**			**$360.00**		
								Prov ID Totals	**2**			**$360.00**		
Tax ID: Sub ID: **0000**														
20002132551521	291356	A			215290	N			O	2	83891	$10.01	08/03/00	06
20002132551521	291356	A			215290	N			O	3	83898	$28.85	08/03/00	06
20002132551521	291356	A			215290	N			O	5	83912	$29.40	08/03/00	06
20002272545854	114374	A			215290	N			O	1	83891	$10.01	08/17/00	06
20002272545854	114374	A			215290	N			O	2	83891	$10.01	08/17/00	06
20002272545854	114374	A			215290	N			C	3	83892	$12.01	08/17/00	06
20002272545854	114374	A			215290	N			C	4	83892	$12.01	08/17/00	06
20002272545854	114374	A			215290	N			C	5	83894	$8.49	08/17/00	06
20002272545854	114374	A			215290	N			C	6	83894	$8.49	08/17/00	06

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REPORT CATEGORY:	Claim Report
REPORT MENU HIERARCHY AND FORMAT NAME:	REPORT ⇒CLAIM REPORTS ⇒REASON CODE EXPLANATION ⇒**INDIVIDUAL CLAIMS**
PRINTED REPORT TITLE:	Reason Code Explanation Report Individual Claims
REPORT DESCRIPTION:	This report provides a listing of the explanations associated with reason codes on individual claims. The Duplicate Claims System requires that an explanation be entered when certain reason codes are used to describe why a claim is or is not a duplicate claim. This report prints the reason code explanation associated with a claim. Individual claim data is grouped within their respective sets. The fields displayed on this report are: Owner FI; Region; Set Number; Set Status; Initial Load Date; ICN; Time Stamp; Responsible FI; PTC Date; Dupe Flag Indicator; Reason Code; and Reason Code Explanation.
REPORT PARAMETER OPTIONS:	Users may customize the report by selecting: All "Standard" parameters (Claim Set Status, Adjustments, Set Owner Type, Claim Type, Match Type, Date Type, Set Range, FI, Region) plus Responsible FI, Region, and Reason Codes.
REPORT NOTES:	The data used by this report format is claim level data.

03/09/2002 **INSTITUTIONAL CLAIMS WORKSHEET** Page 1

Status Codes = ALL
Adjusted Type = ALL
Set Owner Type = ALL
Claim Type = ALL
Match Type = ALL
FI Code = ALL
Region Code = ALL
Set Range = >=1,<=100
Solicited = ALL

Region

ICN	S FX	USR	S ?	SET #	PTC DATE	RE FI	SPON SSAN	PATIENT NAME	PROVIDER TAX ID	PROV SUB-ID	DIAG[1]	DRG	AMT BILLED	AMT PAID	NET GOVT PAID AMT	DUPE? (Y/N)	RSN CD	RECOUP/ RFND AMT
9942291298092	A			17	08/18/94					0000	29633	000	$554.00	$320.00	$272.00	-----	-----	---------
9942311298375	A			17	10/03/94					0000	29633	000	$8,038.00	$4,480.00	$3,808.00	-----	-----	---------
9942434706972	A			58	10/20/94					0000	311	000	$40,677.28	$8,404.00	$8,404.00	-----	-----	---------
9942454797399	A			58	09/12/94					0000	29620	000	$4,433.54	$3,438.00	$3,438.00	-----	-----	---------
9941121298252	A			94	10/13/94					0001	31381	000	$1,045.27	$510.00	$510.00	-----	-----	---------
9942341216190	A			94	09/01/94					0001	31381	000	$14,482.23	$11,280.00	$6,953.86	-----	-----	---------

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REPORT CATEGORY:	Claim Report
REPORT MENU HIERARCHY AND FORMAT NAME:	REPORT ⇒CLAIMS ⇒WORKSHEETS ⇒**NON-INSTITUTIONAL**
PRINTED REPORT TITLE:	Non-Institutional Claims Worksheet
REPORT DESCRIPTION:	This report resembles the paper duplicate claims reports provided to contractors in the past. This report lists the sets of non-institutional line items in OPEN status and provides space for entering by hand: 1) a "Y" or an "N" to indicate if the claim has been determined to be a duplicate or not; 2) a reason code for why the claim is or is not a duplicate; and 3) a recoupment or refund amount. This report provides the contractor with the ability to distribute the claim sets requiring research and duplicate determinations among several personnel. Once completed, these reports can be returned to the system operator for data entry. This report is limited to only non-institutional claims. The fields displayed on the report are: Owner FI; Region; ICN; Claim Level User Defined Code; Solicited Indicator; Set Number; Responsible FI; Sponsor SSAN; Patient Name; Provider Tax ID; Provider Sub-ID; Diagnosis; Line Item Number; CPT-4 Code; Line Item Amount Billed; Line Item Paid Amount; "Dupe? (Y/N)"; Reason Code; and Identified Recoupment or Refund Amount. The report identifies and prints all of the sets meeting the criteria selected on the report parameter screen. The report groups the claims in ascending set number order.
REPORT PARAMETER OPTIONS:	Users may customize the report by selecting: All "Standard" parameters minus Status, Claim Type (Adjustments, Set Owner Type, Match Type, Date Type, Set Range, FI, Region) plus Dupe Flag Indicator, PTC Dates, Responsible FI, and Region.
REPORT NOTES:	The data used by this report format is line item level data.

03/09/2002 **NON-INSTITUTIONAL CLAIMS WORKSHEET** Page 1

Status Codes = ALL
Adjusted Type = ALL
Set Owner Type = ALL
Claim Type = ALL
Match Type = ALL
FI Code = ALL
Region Code = ALL
Set Range = >=500,<=800
Solicited = ALL

99 -

Inactive -

ICN	S FX	USR CD	S ?	SET #	RESP FI	SPON SSAN	PATIENT NAME	PROVIDER TAX ID	PROV SUB-ID	DIAG[1]	LI	CPT-4 CODE[1]	AMT BILLED CPT-4 CD	AMT PAID CPT-4 CD	DUPE? (Y/N)	RSN CD	RECOUP/ RFND AMT
19942450610144	B			546	99				A033	31400	1	90844	$280.00	$216.80	-----	-----	---------
19942510640309	B			546	99				A033	30723	1	90844	$560.00	$433.60	-----	-----	---------
19940830610180	A			547	99				A033	31400	3	90844	$280.00	$216.80	-----	-----	---------
19942510640309	B			547	99				A033	30723	4	90844	$840.00	$650.40	-----	-----	---------
19940940616755	A			548	99				A033	30723	1	99232	$90.00	$61.40	-----	-----	---------
19942510640309	B			548	99				A033	30723	7	99232	$90.00	$61.40	-----	-----	---------
19941740613080	A			566	99				0000	27700	3	06879	$65.00	$65.00	-----	-----	---------
19941740613080	A			566	99				0000	27700	4	06877	$97.25	$88.41	-----	-----	---------
19941820615030	A			566	99				0000	27700	1	06870	$65.00	$65.00	-----	-----	---------
19941820615030	A			566	99				0000	27700	2	06876	$97.25	$97.25	-----	-----	---------

Inactive - CA/HI 88C

ICN	S FX	USR CD	S ?	SET #	RESP FI	SPON SSAN	PATIENT NAME	PROVIDER TAX ID	PROV SUB-ID	DIAG[1]	LI	CPT-4 CODE[1]	AMT BILLED CPT-4 CD	AMT PAID CPT-4 CD	DUPE? (Y/N)	RSN CD	RECOUP/ RFND AMT
19941920640028	A			531	99				0000	4111	1	33533	$2,100.00	$490.70	-----	-----	---------
19941920640028	A			531	99				0000	4111	2	36489	$240.00	$240.00	-----	-----	---------
19941920640028	A			531	99				0000	4111	3	36620	$180.00	$180.00	-----	-----	---------
19941920640028	B			531	99				0000	4111	1	33533	$2,100.00	$2,100.00	-----	-----	---------
19941920640028	B			531	99				0000	4111	2	36489	$240.00	$240.00	-----	-----	---------
19941920640028	B			531	99				0000	4111	3	36620	$180.00	$180.00	-----	-----	---------

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REPORT CATEGORY:	Claim Report
REPORT MENU HIERARCHY AND FORMAT NAME:	REPORT ⇒CLAIM REPORTS ⇒**CLAIM LEVEL USER CODES**
PRINTED REPORT TITLE:	Claim Level User Defined Field Definitions
REPORT DESCRIPTION:	This report displays the Owner FI; Contract Number; the Claim Level User Defined Codes; their definitions, and whether they are active or inactive.
REPORT PARAMETER OPTIONS:	Users may not customize this report.
REPORT NOTES:	The data used by this report format is claim level data.