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for William C. Richard

Laura Sells
Chief, Purchased Care Procurement Branch

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CHAPTER 9

TRICARE DUPLICATE CLAIMS SYSTEM - HCSR VERSION

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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., 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: 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

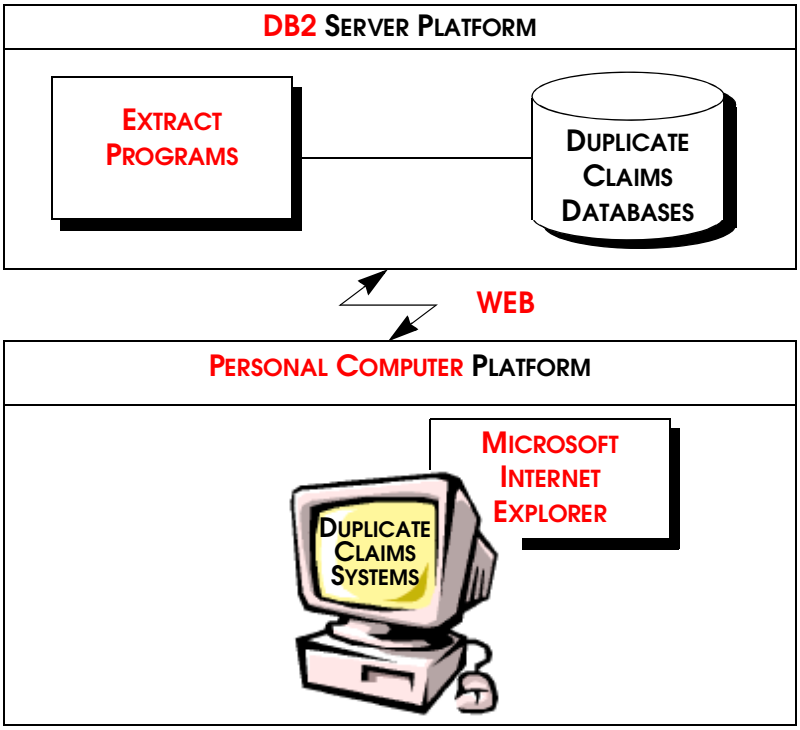
The PC platform is composed of *PCs using MSIE, Version 5.5, 6.0, or 7.0 or as directed by the Government*. *These PCs may be stand-alone or networked computers. The PCs must have Internet access.*

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* communications. 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.

QUICK START INSTRUCTIONS

This section provides instructions for using the Duplicate Claims System *(DCS)*. The following components *are necessary* to access the system:

- A *DCS* User ID and password
- *Microsoft® Internet Explorer (MSIE), Version 5.5, 6.0, or 7.0 or as directed by the Government*
- The Government's *Internet/Nonsecure Internet Protocol Router N*etwork *(NIPRNET)*

Quick Start Instructions assume familiar*ity* with the *personal computer (*PC*)* environment, Windows®, and Health Care Service Record (HCSR) data. Instructions are presented in the following order:

- Entering and Exiting the System
- Setting a View
- Looking for a Claim Set, *Internal Control Number (*ICN*)*, or Social Security Account Number *(SSAN)*
- Identifying a Duplicate Claim
- Resolving a Duplicate Claim Set
- Working with Multi-Contractor Sets
- Creating a Report
- Changing *a* Password
- Using the HELP system

The *DCS* verifies that *the* User ID and password are authorized. This process also identifies *the user's* organization and determines which claim records from the Duplicate Claims *d*atabase can *be* view*ed*. For example, if *the user is* associated with Contractor 1, *they* will have access to Contractor 1 data only. The system uses an **Owner FI** field for each claim set to assign ownership of each set to a specific contractor.

1.0. ENTERING AND EXITING THE *DCS*

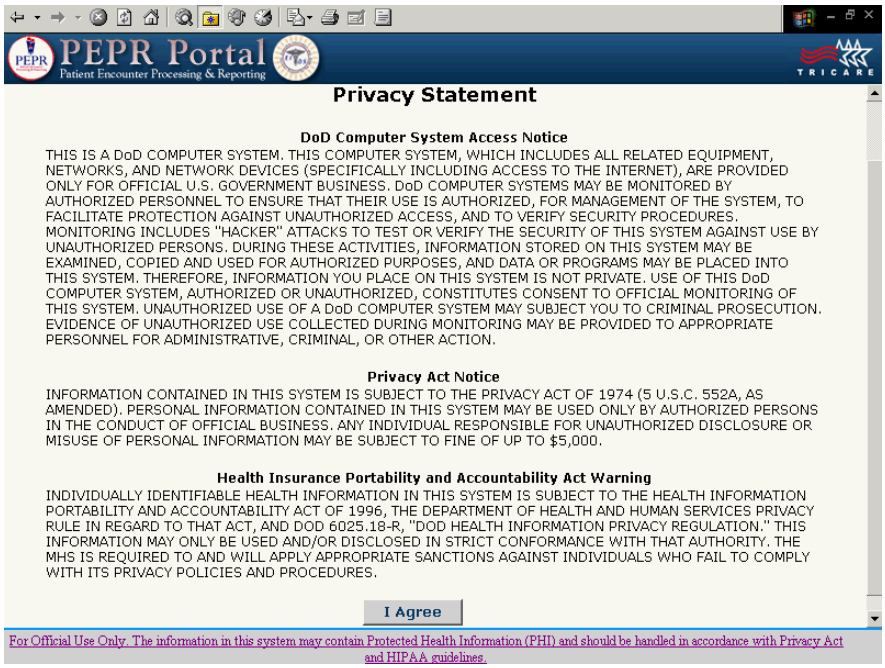
1.1. *To access the DCS, start up the MSIE browser. Go to the DCS web address: https://peprsite.csd.disa.mil/pepr/pepr/*.

1.2. *The COMMON ACCESS CARD (CAC) SCREEN (Figure 9-2-1) will be displayed. Until the Common Access Card (CAC) process has been implemented, click on the "If you don't have a CAC, click here" option.*

FIGURE 9-2-1 COMMON ACCESS CARD (CAC) SCREEN

1.3. *The PRIVACY STATEMENT SCREEN in the Patient Encounter Processing and Reporting (PEPR) Portal (Figure 9-2-2) will be displayed. Read it and then click the* ***I AGREE*** *button.*

FIGURE 9-2-2 PRIVACY STATEMENT SCREEN

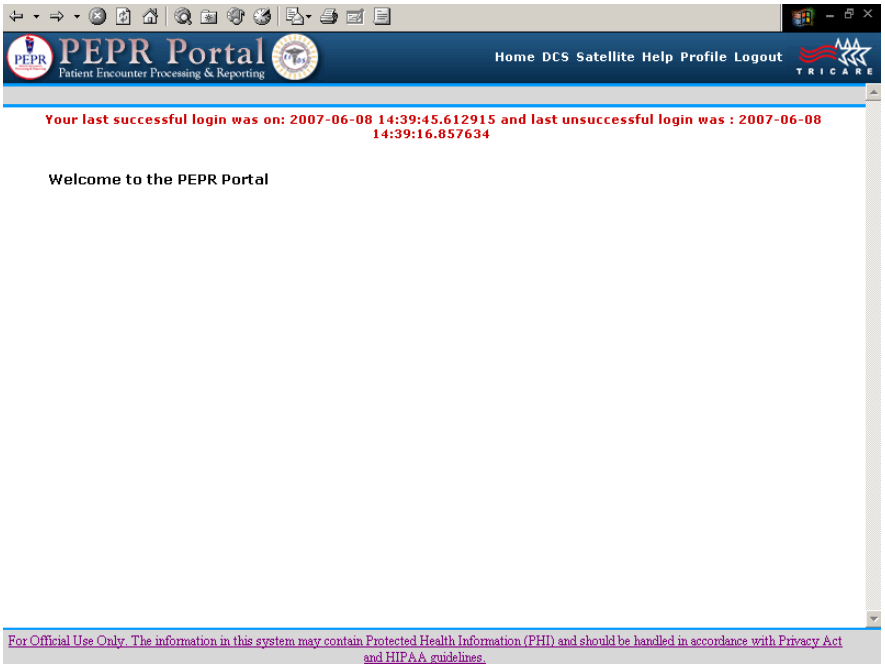


1.4. *The user will then be prompted to enter their user ID and password (Figure 9-2-3). (If the User ID and password are not accepted by the system, call the* ***MHS Help Desk*** *at* ***1-800-600-9332****.)*

FIGURE 9-2-3 USER ID/PASSWORD SCREEN

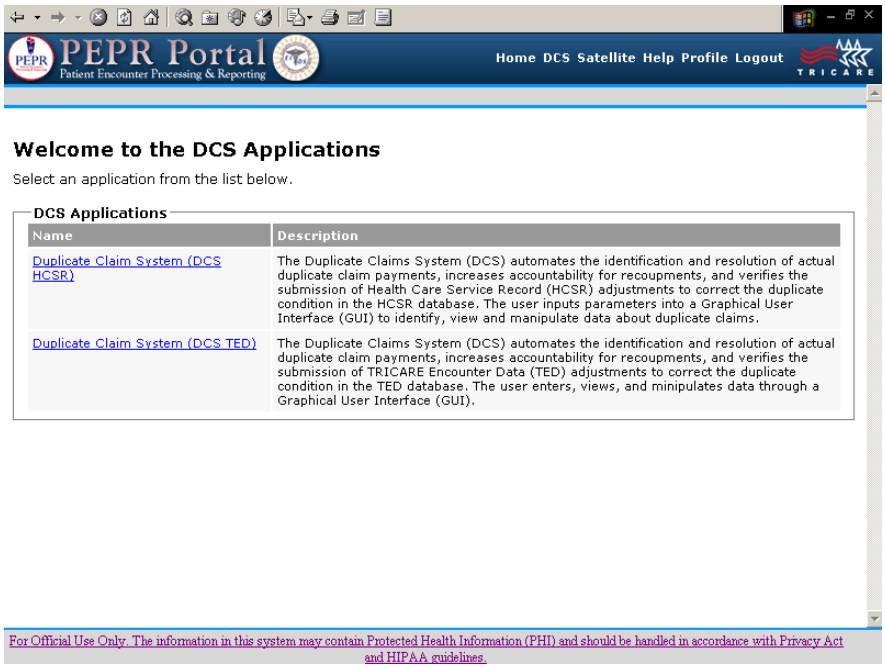
1.5. *The PEPR PORTAL SCREEN (Figure 9-2-4) will be displayed. Click on the* ***DCS*** *link on the PEPR Portal Toolbar (in the upper right side of the screen).*

FIGURE 9-2-4 PEPR PORTAL SCREEN



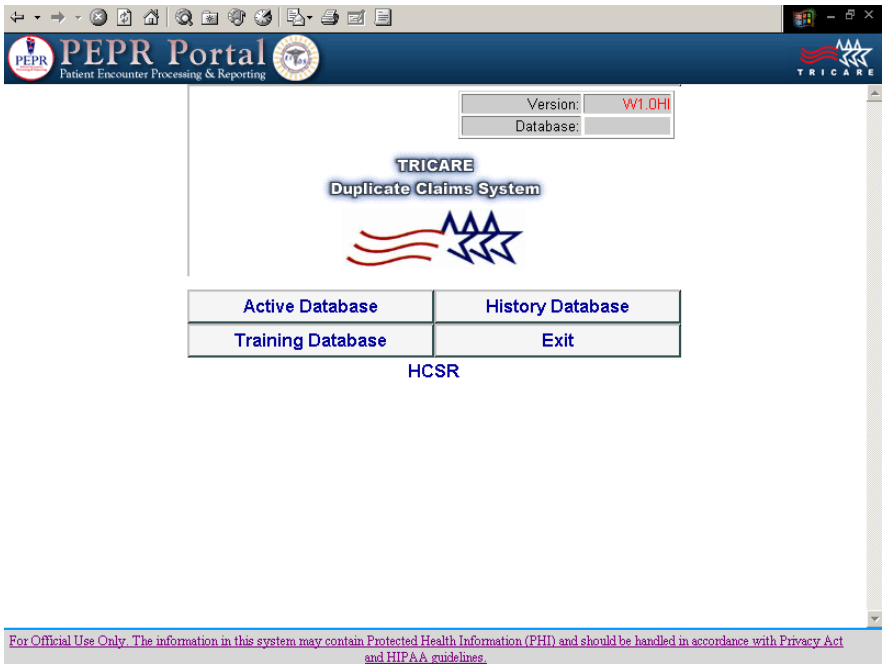
1.6. *The DCS SYSTEM SCREEN is displayed (Figure 9-2-5). Click on the* ***DCS HCSR*** *link.*

FIGURE 9-2-5 DCS SYSTEM SCREEN



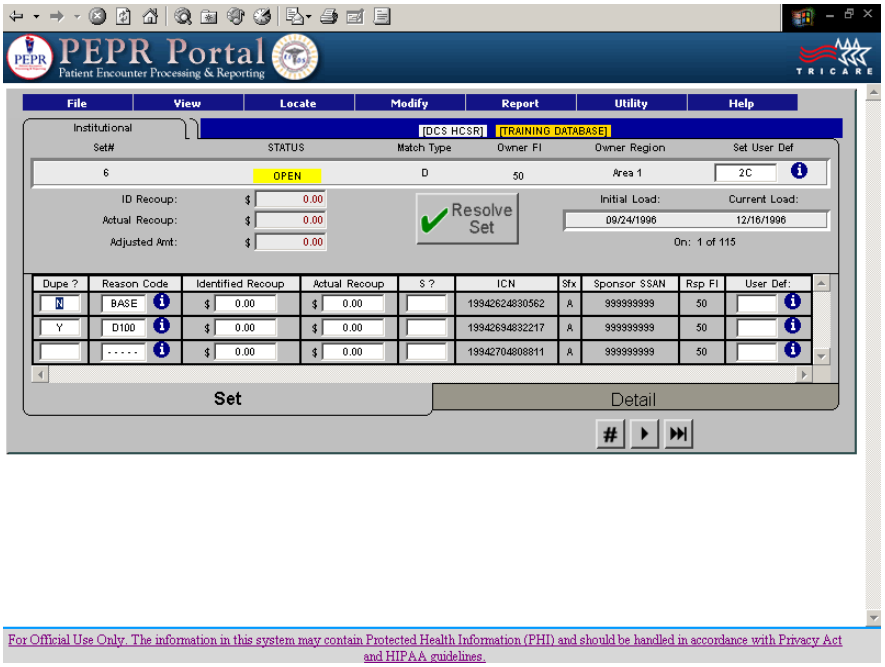
1.7. The TRICARE *DCS* ACCESS SCREEN *(Figure 9-2-6) will be displayed*. Th*is screen* provides the options of clicking on the **ACTIVE DATABASE** *or* **HISTORY DATABASE** button to *access* the *production DCS*, clicking on the **TRAINING** button to *access* the system using *the* training database, or clicking on the **EXIT** button to go back to *the PEPR Portal*.

FIGURE 9-2-6 TRICARE DCS ACCESS SCREEN



1.8. *By clicking on the **ACTIVE DATABASE** or **HISTORY DATABASE** button(s)*, a box with the message: "**Accessing Database. Working... Please wait...**" *will be displayed.* When access has been *achieved*, the SET SCREEN will appear *with the* **Set** tab active *(Figure 9-2-7)*.

FIGURE 9-2-7 SET SCREEN



1.9. To exit the *DCS*, click on **File** in the menu bar and click on **Exit** to return to the ACCESS SCREEN. *The user* can *then* click the **EXIT** button to return to *the PEPR PORTAL DCS SCREEN*. *Then click on **Logout** on the PEPR Portal Toolbar (in the upper right section of the screen).*

1.10. To access the training database, click on the **TRAINING** ***DATABASE*** button on the ACCESS SCREEN.

1.11. *If the user elected to access the **ACTIVE DATABASE**,* the first set associated with *the* FI/ Contractor number *will be displayed*. *The user* may move within this set to the CLAIM DETAIL SCREEN or the LINE ITEM DETAIL SCREEN (if the set is a non-institutional set) by clicking on the **Detail** or **Line Item** tab. *The user* may also view the ADJUSTMENT SCREEN if there is an **Adjustment** tab indicating that an adjustment has been processed for one of the claims in the set. (The **Adjustment** tab will only appear when a HCSR adjustment associated with the set has been submitted and accepted and has been loaded to the DCS.)

1.12. *The user* can use the Video Cassette Recorder (**VCR**) buttons at the bottom of the screen to move to the next set (>), the previous set (<), the first set (|<) or the last set (>|). *The user* can also move to a particular set by clicking on the # button.

2.0. SETTING A VIEW

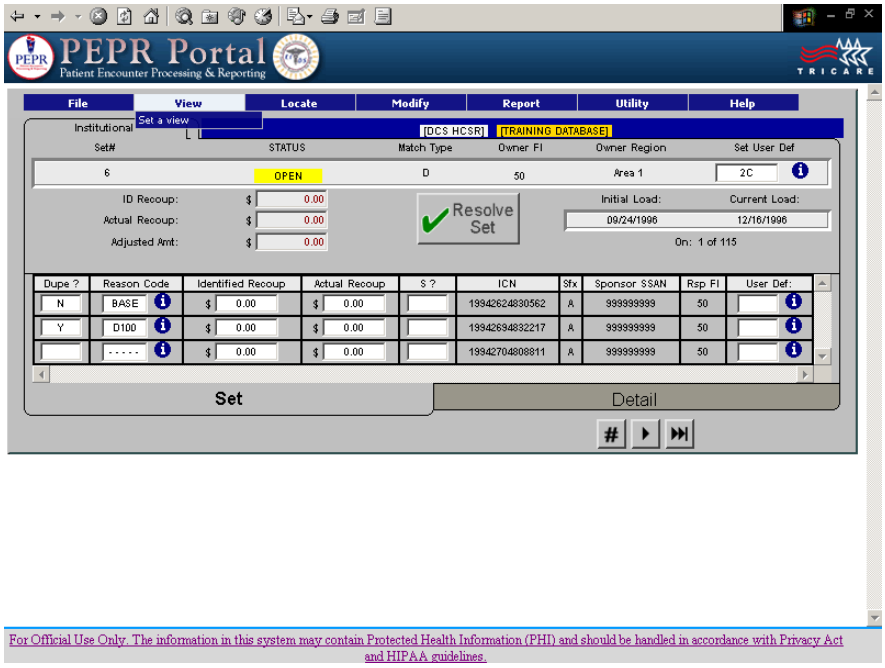
2.1. At any time, *the user* can click the **View** function on the menu bar to limit *the* view to certain categories of claim sets *(Figure 9-2-8)*. The *SELECT DATA VIEW SCREEN*, as shown in

Figure 9-2-9, allows *the user* to specify a subset of claim sets to view. *The user* can select a subset of claim sets by:

- Status code.
- Institutional or non-institutional sets.
- Sets with or without adjustments.
- Single contractor sets or multi-contractor sets.
- Claim match criteria, e.g., exact match, date overlap, CPT-4 code match, *etc*.
- Sets within a date range for processed to completion *(PTC)* date, initial load date, current load date, or last update date.
- Sets belonging to a specific region or a specific contractor.
- *Sets containing claims with selected enrollment codes.*

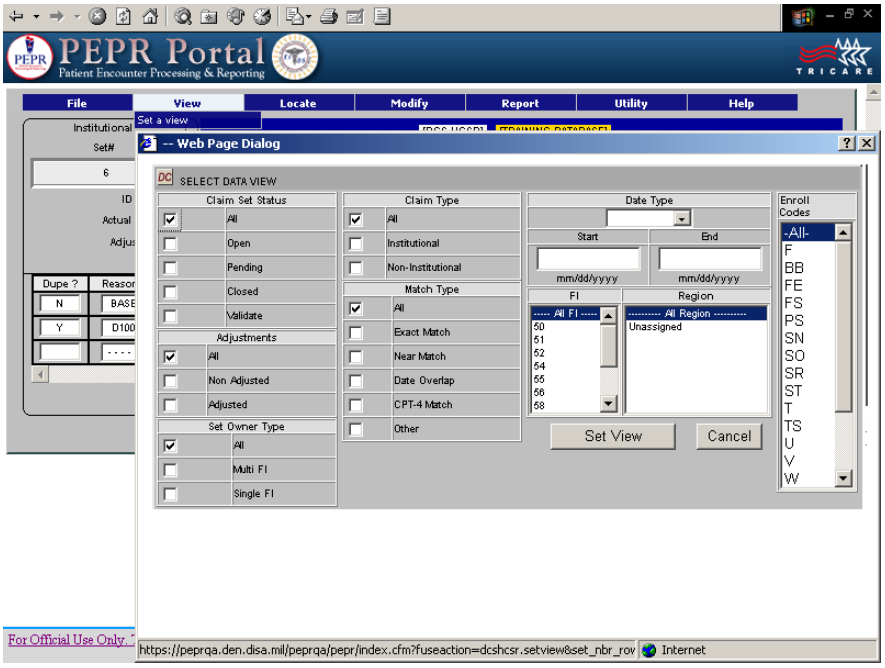
2.2. Sets may be selected by combining various View options. For example, *the user* may request all claim sets with an *Open* status for Region 6 that meet the exact match criteria.

FIGURE 9-2-8 SET A VIEW SCREEN



When *the user* uses the View function, the system will remind *the user* that *a* restricted view of *the* claim sets *is being* displayed *by* "**A View is Set!**" *message* on the screen. The View function also allows *the user* to "Clear a View" and return to full access of all *the user's* claim sets. If *the user* views *the* claim sets by status, *the user* can view *Open* sets to see the sets that have not been researched enough to determine if a duplicate condition exists. Or *the user* can view *Pending* sets to see the sets that have been researched enough to determine that a duplicate payment was made and recoupment is pending. *The user* can *also* view sets *that are in Closed* or *Validate status*. See Chapter 9, Section 4, paragraph 3.0., for additional details about claim set status.

FIGURE 9-2-9 SELECT DATA VIEW SCREEN



3.0. LOOKING FOR A SPECIFIC SET AND MODIFYING SETS

3.1. At any time, *the user* can click the **L**ocate function on the menu bar to view a specific set by Set Number, ICN, or Sponsor SSAN. Upon selection of one of these locate parameters, the system displays the claim set matching the *selected parameters*. If an ICN or SSAN was entered, *the user* can go back to the **L**ocate function and see if other sets match the ICN or SSAN. If they do, the Locate **N**ext and/or Locate **P**revious options are displayed. If a previous or next option is not relevant to the ICN or SSAN, these choices are "grayed out" and not available to *the user*.

3.2. If a claim appears in more than one claim set, the ICN will be displayed in white characters. *The user* can double-click on the white ICN to view the set in which this same claim appears. *When the user double-clicks on the white ICN in the "next" set, the system* will prompt *the user* to move to the "Next" or "Previous" set, as appropriate.

3.3. A shortcut to locating a specific set by set number is provided as a **VCR** button at the bottom of the screen (#). To locate a specific set by it's set number, click on the # button, enter the number in the pop up window that appears and click on *the* **OK** *button*.

3.4. In addition to locating a specific set, *the user* may use the **M**odify function to change the **Owner FI** field of a multi-contractor claim set. (See Chapter 9, Section 6, for more information about how and when *the user* might want to change the **Owner FI** field.) The **M**odify function also allows *the user* to apply the correct region to a set which has been transferred to *the user*.

3.5. The choices available in the **M**odify function maintain data integrity by allowing *the user* to select only those choices that are appropriate to the situation. In other words, the choices available to *the user when* changing the **Owner FI** of a set include only those **Responsible FI**s *associated with* the claims in that set.

3.6. The **M**odify function also has a Government option available to a limited number of *the TRICARE Management Activity (*TMA*)* users who are authorized to change the status of sets. The system-assigned status of a set will only be overridden by TMA in consult with the applicable contractor.

4.0. IDENTIFYING A DUPLICATE CLAIM

When view*ing* a claim set, *the user* should understand that every claim set contains potential duplicate claims, i.e., two or more payments made for *the same* services for the same beneficiary on the same dates of service. Refer to *Section 3*, *to* see the criteria used to select potential duplicate claims. The type of match criteria used to select potential duplicate claims ranges from an "Exact" match in which 14 fields are the same, to an "Other" match in which *four or* five fields are the same*, depending on whether the set involves institutional or non-institutional claims*.

To view these fields and others in the CLAIM DETAIL SCREEN and LINE ITEM DETAIL SCREEN (non-institutional claims only) *while researching the claims in the set*. Note that institutional claims are matched at the claim level and non-institutional claims are matched at the line item level. *To* print out the data as they appear on these screens by accessing the **F**ile function on the menu bar and *selecting* **Print**. *The user* will need to conduct *the* research on *the user's* proprietary claims processing system and pull claim copies, when necessary to comply with other contract requirements (e.g., duplicate prevention requirements, recoupments, etc.), to determine if an actual duplicate payment was made.

5.0. RESOLVING A DUPLICATE CLAIM SET

To resolve a claim set, *the user* must:

- *C*onduct research
- *D*etermine the amount of overpayment, if any
- *I*nitiate recoupment action, if required
- *R*ecord actual refunds/offsets received, if any
- *S*ubmit HCSR adjustments, where required and
- *A*pply any HCSR adjustments loaded to the DCS.

5.1. Steps Of Resolution

To resolve a claim set, *the user* must enter data in at least two fields for sets involving no duplicate overpayments and five fields for sets containing actual duplicate overpayments. (*The user* may also enter data into three additional, optional fields if the Managed Care Support Contractor *(MCSC)/TRICARE Dual Eligible Fiscal Intermediary Contractor (TDEFIC)* finds this optional data valuable.) **Note:** *The user* may be prompted to type in an explanation for the data *that was* enter*ed*. This is explained below.

5.1.1. On the CLAIM SET SCREEN, *the user* may enter a 'Y' in the **Dupe?** field of a claim to identify it as a duplicate payment or enter a 'N' in the **Dupe?** field of a claim to identify it as a non-duplicate payment.

5.1.2. For each 'Y' or 'N' entered on a claim-level line, *the user* must select a valid reason code to explain why the claim is a duplicate or non-duplicate. Some reason codes also require a free text explanation.

5.1.3. For each 'Y' claim identified as a duplicate payment, *the user* must enter an identified amount for recoupment.

5.1.4. For each 'Y' claim identified as a duplicate payment, *the user* may enter an amount actually recouped.

5.1.5. On the ADJUSTMENT SCREEN, *the user* may identify the HCSR adjustment transaction that corrects the duplicate condition in the HCSR database by entering a 'Y' in the **HCSR Adjust?** field of the adjustment displayed for the duplicate claim.

A duplicate claim set *can be resolved* in one of three ways:

- Indicate that no duplicate condition exits, enter a 'N' in the **Dupe?** field of all non-BASE claims, provide a non-duplicate reason code, and click the **RESOLVE THE SET** button to resolve the set and change the status to *Closed*.

- Indicate that one claim is a duplicate, enter a 'Y' in the **Dupe?** field, enter the amount identified for recoupment, enter the amount actually recouped, flag the appropriate HCSR adjustment that corrects the duplicate condition in the HCSR database, and click the **RESOLVE THE SET** button to resolve the set and change the status to *Closed*.

- Indicate that one claim is a duplicate, enter a 'Y' in the **Dupe?** field, enter the amount identified for recoupment, show that the amount actually recouped is less than the amount identified for recoupment, flag the HCSR adjustment (if any), click the **RESOLVE THE SET** button to resolve the set, enter an explanation for the lesser amount recouped, and allow the system to change the status to *Validate*.

The user can invoke the system's rules of resolution to resolve claim sets by clicking the **RESOLVE THE SET** button. When the **RESOLVE THE SET** button is clicked, the rules of resolution are invoked and the system determines if the set can be moved from *Open/Pending* to *Closed/Validate*. The end result of the status depends on the conditions in the set.

5.2. Rules Of Resolution

RULE 1: All claims in the set must have 'Y' or 'N' in the **Dupe?** field and a corresponding reason code.

RULE 2: There must be one claim that is labeled the BASE claim. This claim must have a 'N' in the **Dupe?** field.

RULE 3: All 'Y' claims must have an amount identified for recoupment greater than $0.00. When the first three rules are met, the status of the set changes to *Pending*.

RULE 4: If one or more actual duplicates are identified, but no amount can be recouped, the set can be resolved to a status of *Validate* if an explanation is provided.

RULE 5: If one or more actual duplicates are identified but the full amount identified for recoupment cannot be recouped (i.e., the actual recoupment amount is less than the identified amount for recoupment), the set can be resolved to a status of *Validate* if the total HCSR adjustment amounts reflect the partial recoupment amount and an explanation for the reason the full amount could not be recouped is provided.

RULE 6: If one or more actual duplicates are identified but the amount actually recouped is $10.00 or less and the contractor does not intend to submit a HCSR adjustment for $10.00 or less for the refund/offset, the system will permit the set to be resolved to a *Validate* status provided that an explanation is entered.

RULE 7: If one or more actual duplicates are identified and the total amount identified for recoupment equals the total amount actually recouped and the total HCSR Adjust Amount is greater than or equal to the total actual recoupment amount, the set can be resolved. The *DCS* assumes that every duplicate non-institutional claim has corresponding HCSR adjustments for every line item identified in the DCS as a potential duplicate. If one or more line items of a non-institutional claim are determined to be non-duplicates, corresponding HCSR adjustments will not be submitted and the system will not allow the set to be resolved to a *Closed* status. It will allow the set to be resolved to a *Validate* status, provided that an explanation is entered. Resolution results depend on the following conditions:

- If there is a corresponding HCSR adjustment for each institutional claim or each non-institutional line item in each claim identified as an actual duplicate, the set can be resolved to a *Closed* status without any explanation.

- If there is not a corresponding HCSR adjustment for each institutional claim identified as an actual duplicate, the set can be resolved to a *Validate* status with an explanation for the reason corresponding adjustments were not submitted.

- If a non-institutional claim set contains a non-duplicate line item, the system will recognize that adjustments have not been flagged for all of the identified line items. In this situation, the user can explain that one or more of the line items was not a duplicate and the set can be resolved to a *Validate* status.

RULE 8: If all claims in the claim set have an 'N' in the **Dupe?** field, a valid 'N' reason code, $0.00 in the amount identified for recoupment and in the amount actually recouped for each claim, the set can be resolved to a *Closed* status. Some reason codes may require an explanation.

RULE 9: To resolve a claim set and change its status to *Closed* or *Validate*, the user must click the **RESOLVE THE SET** button. If the rules of resolution that apply to changing the status of a set from *Open/Pending* to *Closed/Validate* are met, the status of the set will be changed. If the rules of resolution are not met, the status of the set will not be changed.

RULE 10: The user can click the **UPDATE CHANGES** button to change the status of a claim set from *Open* to *Pending* or from *Pending* to *Open*. If the rules of resolution are not met, the status of the set will not be changed.

RULE 11: The user can leave a set and allow the system to automatically update the database and invoke the rules of resolution for changing the status from *Open* to *Pending* or from *Pending* to *Open*. If the rules of resolution are not met, the status of the set will not be changed.

The rules of resolution delineated above are overruled in *three* situations:

- In multi-contractor sets, the system ignores the claims in the set in which the **Owner FI** is not the **Responsible FI**, except for the BASE claim. It allows an **Owner FI** to move a set to a *Pending* status if there is one BASE claim and all the **Owner FI**'s claims meet the general conditions for *Pending*. That is: all **Owner FI** claims must have a **Dupe?** field entry and a reason code, there must be one 'Y' claim, and every 'Y' claim must have an identified recoupment amount greater than $0.00. See *Section 6, paragraph 2.0.,* for additional details.

- When a single contractor set is appended with a new claim, the status of the set becomes *Open*. When a multi-contractor set in *Open* status is appended with a new claim, the status of the set remains *Open*. When a multi-contractor set in *Pending* status is appended, the status of the set remains *Pending*. When a multi-contractor set in *Closed* status is appended, the status of the set is changed to *Open*. When a multi-contractor set in *Validate* status is appended, the status of the set is changed to *Pending*. See *Section 4, paragraph 5.0.,* for additional details.

- *Rule 8 does not apply to multi-contractor sets. In multi-contractor sets there must be at least one claim with a 'Y' in the **Dupe?** field.*

5.3. The RESOLVE THE SET, UPDATE CHANGES, And UNRESOLVE THE SET Buttons

The **RESOLVE THE SET** button and the **UPDATE CHANGES** button perform different resolution functions:

5.3.1. If *the user* wants to invoke the rules of resolution to see if the status of a set can be changed from *Open* to *Pending* or *Pending* to *Open*, *the user* must use the **UPDATE CHANGES** button.

5.3.2. If *the user* wants to invoke the rules of resolution to see if the status of a set can be resolved to a *Closed* or *Validate* status, *the user* must use the **RESOLVE THE SET** button.

5.3.3. *The user* cannot resolve a set to *Closed* or *Validate* status with the **UPDATE CHANGES** button.

5.3.4. If *the user* uses the **RESOLVE THE SET** button, the system will invoke the rules of resolution to determine if the status of the set can be changed to *Closed* or *Validate*. If neither of these conditions are met, the system will explain why the set cannot be resolved and will maintain the current status, i.e., *Open* or *Pending*.

If *the user* moves to another set after data on a set with an *Open* status *has been entered*, the system will automatically update the database with this new data and determine if the set meets the conditions for a *Pending* status. The change in status, if appropriate, will be made automatically, just as if the **UPDATE CHANGES** button *had been clicked*. Similarly, a *Pending* status will be changed to *Open* status if the rules dictate the set no longer meets the conditions for a *Pending* status. Note, however, that even if the set meets the conditions for a *Closed* or *Validate* status, this change will not be made automatically by the system. *The user* must use the **RESOLVE THE SET** button to change the status of a set to *Closed* or *Validate*.

The **UPDATE CHANGES** button appears on the screen whenever *the user* enters data. *The system* alerts *the user* to the fact that *new data has been* entered but this data has not been committed to the Duplicate Claims database. When the **UPDATE CHANGES** button *has been clicked*, *the user* will be prompted to *select* one of the following:

- "Yes" to commit the changes to the database
- "No" to rollback all the changes just made
- "Cancel" to terminate the update function and return to the previous screen

If *the user* chooses to commit the changes to the database, logic will be invoked to determine if the changes meet the rules of resolution for changing the status of the set from *Open* to *Pending* or from *Pending* to *Open*.

If *the user* chooses to rollback the changes just made, the screen will be reset to the way it was the last time the database was updated.

If *the user* chooses to cancel the operation, the update will not occur and *the user* will be back on the screen with the changes displayed but not committed to the database.

The **RESOLVE THE SET** button changes to an **UNRESOLVE THE SET** button when a claim set has been resolved and its status changed to *Closed* or *Validate*. New *data* cannot be entered into a set in *Closed* or *Validate* status. If *the user* wants to change data in a *Closed* or *Validate* set, *the user* must first unresolve the set by clicking the **UNRESOLVE THE SET** button, which automatically changes the status of the set to *Pending* or *Open*.

In the *DCS*, *Open* and *Pending* are "working" statuses and *Closed* and *Validate* are "resolved" statuses. New data can be entered or changes to data can be made only to sets in a "working" status.

The **RESOLVE THE SET** and **UPDATE CHANGES** buttons described above allow *the user* to take definitive action to resolve and update a claim set. The system also has several default functions to manage these processes when *the user* enters new data and does

not click the **UPDATE CHANGES** button. In other words, if *the user* leaves the claim set after entering data by one of the methods listed below, the system assumes *the user* forgot to click the **UPDATE CHANGES** button, and will do it. It also assumes *the user* wants to update the claim set with the data *that was* entered. In updating this data, the system invokes the rules of resolution to determine if the claim set meets the rules of resolution for changing the status of the set from *Open* to *Pending* or from *Pending* to *Open*. These actions will be triggered when *the user* leaves the claim set by one of the following methods:

- Click on one of the **VCR** movement buttons to move to the first, next, previous, or last claim set.
- Click on the **V**iew or **L**ocate menu bar function to move to a different claim set specified by the **V**iew or **L**ocate criteria.
- Click on the # **VCR** movement button to move to the claim set *the user* specifies.
- Exit from the *DCS.*

Be aware, however, that there is no default function for changing the claim set status to *Closed* or *Validate*. The only way a claim set can be fully resolved and the status changed to *Closed* or *Validate* is by clicking the **RESOLVE THE SET** button.

6.0. WORKING WITH MULTI-CONTRACTOR SETS

The important thing to remember when working with multi-contractor sets is that in every multi-contractor set, one or more jurisdictional errors were committed. One or more claims were paid by a contractor who did not have jurisdiction to do so. There must be at least one 'Y' claim in every multi-contractor set. If *the user is* the **Owner FI**, *the user* can view the set and enter data to try and resolve the set. If *the user is* not the **Owner FI** but paid one of the claims in the set, *the user* will not be able to view the set and, therefore, will not know that a jurisdictional error has been made until the **Owner FI** contacts *the user*.

The system designates the contractor who processed the latest claim as the **Owner FI**. If, after the two contractors discuss the jurisdictional facts, the other contractor (not the **Owner FI**) is the one responsible for the jurisdictional error, the current **Owner FI** should enter 'N' in the **Dupe?** field and a reason code, including BASE, if appropriate, for its claim, then change the **Owner FI** field to the other contractor by clicking the **M**odify function on the menu bar and selecting the **Owner FI** option. The contractor who processed the other claim in the set will be displayed so that *the user* can click on this contractor and change the **Owner FI** field to the other contractor. *The user* will be required to document that *the user* discussed this change in ownership with the other contractor and received approval to make the transfer. See *Section 6*, for additional details.

7.0. CREATING A REPORT

The user can click on the **R**eport function of the menu bar at any time to generate a report. *The user* have a choice of report formats and selection parameters from which to choose the layout and content of the report. For each report type, e.g., set reports, claim reports, summary/management reports, and graphs, *the user* will be prompted to select

subsets within this report type (if applicable) *and* will be shown the REPORT PARAMETER SCREEN that looks similar to the **V**iew function screen. The REPORT PARAMETER SCREEN enables *the user* to select the claim types and set types that will be included in the report. See Chapter 9, Section 8, for more details about using the **R**eport function.

8.0. CHANGING *A* PASSWORD

Passwords *can be changed* at any time, *j*ust click on the ***Profile*** *link on the PEPR Portal Toolbar (in the upper right side of the screen)* and follow the prompts. Passwords must have at least *nine but not more then 12* characters and use *at least two of each of the following: u*ppercase, *l*owercase, *n*umbers, and *s*pecial *c*haracters [**! @ # $ % ^ * ( )** _]. *Passwords can be changed only once every 24 hours.*

9.0. USING THE HELP SYSTEM

If *the user* need*s* additional assistance beyond *that provided by* this chapter, *the user* can call the ***MHS Help Desk*** *in San Antonio at* ***1-800-600-9332****, then follow the prompts to the DCS*.

DUPLICATE CLAIMS DATA

The Duplicate Claims System *(DCS)* performs several functions for the maintenance of the *DCS d*atabases. First, it identifies, selects, and extracts potential duplicate claims from the Health Care Service Records (HCSRs) database. It then groups potential duplicate claims into sets and stores these claims in the *DCS* Active *d*atabase. Subsequently, it identifies adjustment and cancellation transactions processed by the HCSR system associated with claims in the *DCS* Active and History *d*atabases and attaches these adjustment transactions to their associated sets. In attaching adjustment/cancellation HCSR transactions to their associated sets, the system enables users to verify that duplicate payment records have been removed from the HCSR 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 HCSRs for submission to the *TRICARE Management Activity (*TMA*)*. HCSRs reflect specific claim/encounter processing activity and document health care services and associated payment actions. HCSRs 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 HCSRs, are detectable by TMA. When duplicate payments are identified, contractors are expected to initiate recoupment action. Upon receipt of the refunds or offsets, adjustment HCSRs should be submitted to reflect the recoupments. When adjustments are added to the HCSR database, the duplicate payments are corrected, and the duplicate conditions are removed from the HCSR database.

The correction of the HCSR database is a critical function of the *DCS*. Not only do duplicate HCSRs represent overpayments, their very existence in the HCSR 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 HCSRs 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 HCSRs became DCS sets and what happened to these sets over time within the DCS.

1.1. Contractors submitted HCSRs approximately daily to the Defense Information Systems Agency (DISA) site at Mechanicsburg, Pennsylvania where the HCSRs were housed on an IBM-compatible mainframe.

1.2. On a monthly basis, TMA processed the HCSRs received during the previous month and compared them to the previous 12 months of HCSR Net data to identify potential duplicate claims. The identified potential duplicate claims became the DCS monthly extract.

1.3. *TMA transferred the monthly extracts to the DB2 Server where they were processed and placed into the DCS Active database.*

1.4. Now, TMA processes the daily HCSR data received from the contractors and extracts any adjustments and cancellations to HCSRs previously identified as potential duplicates in the monthly extract and that reside in the DCS. This extract becomes the DCS daily extract.

1.5. TMA transfers the daily extracts to the DB2 Server where they are processed and placed into the DCS Active database.

1.6. DCS users work the sets in the DCS Active database.

1.7. After specified conditions have been met and time periods have elapsed, DCS sets are moved to the DCS History database.

1.8. After a specified period of time, the DCS sets are deleted from the DCS History database.

2.0. CRITERIA USED TO SELECT POTENTIAL DUPLICATE CLAIMS

The DCS uses the criteria described on the following pages to extract HCSR data and load the DCS databases. The DCS inspects up to 14 HCSR data fields in each claim record and, 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

The following categories of match criteria are used to identify and link two or more matched institutional claims. Figure 9-3-1 shows the specific HCSR data field match criteria used to select potential institutional duplicate claims.

Exact Match	All 14 fields match.
Near Match	Six fields match and the lesser Billed Amount is within 10% of the larger Billed Amount.

Date Overlap Four fields match and the beginning date of care of one claim falls between the beginning and ending dates of another.

Other Five fields match.

FIGURE 9-3-1 DATA FIELD MATCH CRITERIA FOR INSTITUTIONAL CLAIMS

FIELD NAME	OTHER	DATE OVERLAP	NEAR MATCH	EXACT MATCH
SPONSOR SSAN	✔	✔	✔	✔
DEERS DEPN SUFFIX	✔	✔	✔	✔
PATIENT DOB				✔
PROGRAM INDICATOR				✔
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 Non-Institutional Claims

The following categories of match criteria are used to identify and link two or more matched non-institutional claims. Figure 9-3-2, shows the specific HCSR data field match criteria used to select potential non-institutional duplicate claims.

Exact Match All 14 fields match.

Near Match Seven fields match and the lesser Billed Amount is within 10% of the larger Billed Amount.

CPT-4 Code Match Six fields and the first three characters of the procedure code match.

Other Six fields match.

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

2.3.1.1. 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 *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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2.3.3. 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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CLAIM SETS AND THE CLAIM SET LIFE CYCLE

An understanding of claim sets and the claim set life cycle is a prerequisite for using the Duplicate Claims System *(DCS)*. All potential duplicate claims are grouped into sets. Each claim set is unique. Each claim set is assigned a unique and sequential claim set number for reference and control purposes.

1.0. DEFINITION OF A CLAIM SET

A claim set is composed of two or more Health Care Service Records (HCSRs) meeting either one of four institutional match criteria, or one of four non-institutional match criteria described in *Section 3, paragraph 2.0.* These match criteria are used by the system to identify and select claims that are potential duplicates.

Each claim set contains one and only one claim record that is initially assigned by the system to be the BASE claim, signifying the claim with the earliest processed to completion *(PTC)* date. By default, the system assumes that the BASE claim is the one least likely (with exceptions) to be a duplicate of another claim in the set because it was processed and paid before the other claim(s) in the set. The non-BASE claim(s) are considered to be potential duplicates.

The assignment of the BASE claim also applies to sets containing claims that were processed by two different contractors. These sets are referred to as multi-contractor sets. In multi-contractor sets, the duplicate payment is assumed to be a result of a jurisdictional processing error. In such cases, the claim with the earliest *PTC* date could be the actual duplicate. In both single contractor claim sets and multi-contractor claim sets, the contractor is able to change the BASE claim assignment and assign a different claim in the set as the BASE claim.

1.1. Institutional Claim Sets

The *DCS* applies *the* institutional match criteria to institutional claims at the claim level to identify potential duplicates. In general, an institutional claim will appear in only one set. If, however, a contractor submits a HCSR adjustment and changes a claim's date of service, the claim may subsequently appear in another set. When a claim appears in more than one set, the *Internal Control Number (*ICN*)* of the claim will be displayed in the CLAIM SET SCREEN in white letters and numbers. Additional claims may be added to a set at any time, providing they meet the match criteria.

EXAMPLE: If institutional claim A and institutional claim B are identified as potential duplicates, they will appear in Claim Set 1. If another claim, institutional claim C, is identified as a potential duplicate of either claim A or claim B, the system will add claim C to Claim Set 1. If an adjustment to claim B changes the dates of

service for the claim, claim B should be labeled as a non-duplicate claim in Claim Set 1. If claim B, as it appears with the revised dates of service, is identified as a potential duplicate of another institutional claim D, claims B and D will be grouped into a new Claim Set 2.

1.2. Non-Institutional Claim Sets

The *DCS* takes a different approach to identifying and linking potential non-institutional duplicate claims. Non-institutional potential duplicates are identified by comparing line item data of one claim with line item data of another claim.

NOTE: The *DCS* does not look for duplicates within a single claim; only among two or more claims.

When a line item of one non-institutional claim is identified as a potential duplicate of a line item of another non-institutional claim, the system groups the claims with the matching line items into a set.

For example, if line item number 5 of claim D is identified as a potential duplicate of line item 7 of claim E, the system will group the two potential duplicate line items into Claim Set 2. Any additional line items on claims D and E identified as potential duplicates of each other will also be included in Claim Set 2 if the beginning date of service is the same as the other potential duplicate line items in the set. All of the line items contained in Claim Set 2 must have the same beginning date of service.

1.2.1. Display Of Line Items In Non-Institutional Claim Sets

Non-institutional sets contain only those line items that have been identified as potential duplicates. Any line item not identified as a potential duplicate will not be included in the claim set. For example, if claim D contains five line items and claim E contains five line items, but only line items 1, 3, and 5 on claim D are identified as potential duplicates of line items 1, 2, and 4 on claim E, the claim set will include only those matched line items. Line items 2 and 4 from claim D and line items 3 and 5 from claim E will not appear in the claim set.

If, after a set has been established, the system detects potential duplicate line items from additional (e.g., a third and fourth) non-institutional claims that match the line items previously identified and have the same beginning dates of service, the system will add the new claims to the existing claim set. If, however, the identified line items from the third and fourth claims have different beginning dates of service, the system will create a new claim set composed of the matching line items from the third and fourth claims as long as they have identical beginning dates of service. If a contractor submits a HCSR adjustment that changes a line item's date of service, the line item may subsequently appear in another set.

For non-institutional potential duplicate claims to appear in the same claim set, the claims must have matching sponsor Social Security Account Numbers *(SSANs)*; patient *Defense Enrollment Eligibility Reporting System (*DEERS*)* Dependent Suffixes *(DDSs)*; provider tax ID and sub-ID numbers; and beginning dates of service.

1.2.2. Examples Of Non-Institutional Claim Sets

1.2.2.1. If Claim Set 4 contains two claims, F and G, with line item 2 on both claims showing services rendered to Sally Jones for an office visit with Dr. Smith on May 1, 1995, these line items would be matched up in one set. Later, however, if claims H and I come in for Sally Jones, both containing a line item for an office visit on October 1, 1995 with Dr. Smith, the system will group the line items with the October 1, 1995 date of service from claims H and I into a new claim set (Claim Set 5). The system will not include them in the claim set containing the line items for the May 1, 1995 office visit (Claim Set 4)---even though the line items are for the same procedure code, for the same beneficiary, and rendered by the same provider---because the beginning dates of care are different. The system will prevent contractors from having to research claims containing line items that are related to different episodes of care within the same claim set.

1.2.2.2. Claim Set 6 contains two claims, J and H, both containing one line item for services rendered to Sally Jones. The line items are for office visits with Dr. Smith on May 1, 1995. Later, claims L and M are received for Sally Jones containing two line items each. Line item 1 on claims L and M is for a minor outpatient surgical procedure for Sally Jones (removal of an ingrown toe nail) by Dr. Smith on May 1, 1995. Line item 2 on both claims *are* for office visits for Sally Jones on June 1, 1995 with Dr. Smith.

The system will match the May 1, 1995, line items from claims L and M with the line items from claims J and K. Claim Set 6 will now contain four line items from four different claims. However, because line item 2 on claims L and M have a different beginning date of service, (June 1, 1995), the system will create a new claim set (Claim Set 7) for line item 2 of claims L and M. These line items will not be added to Claim Set 6.

As a result, claims L and M will appear in both Claim Set 6 and Claim Set 7, with each claim set containing different line items. When the user is researching claims J, K, L, and M in Claim Set 6, the system will alert the user that claims L and M also appear in another claim set by changing the color of the ICN and suffix of Claims L and M from black to white. The system will permit the user to move directly to the "next" or "previous" claim set where L and M appear when the user double clicks on the ICNs shown in white.

1.3. Adjustments And Cancellations Associated With Claims In A Set

Following every HCSR processing cycle, generally on a daily basis, the *DCS* identifies all accepted adjustment and cancellation HCSRs which are associated with any of the HCSRs previously extracted as potential duplicates and residing in the *DCS* Active *d*atabase. These adjustments and cancellations are extracted from the HCSR database and added to the applicable claim sets in the *DCS* Active *d*atabase.

Adjustments to an institutional potential duplicate claim residing in the *DCS* are extracted and linked to the appropriate institutional claim set. Adjustments to a line item of a non-institutional potential duplicate claim residing in the *DCS* are extracted and linked to the appropriate non-institutional claim set.

The provisionally accepted adjustments will display in the DCS but cannot be used to correct the duplicate condition until a subsequent adjustment corrects the provisional condition.

1.4. ICNs Versus Claims

ICNs in the *DCS* do not necessarily equate to a claim. A "claim" is identified by an ICN and a suffix and a time stamp. The *DCS* considers different suffixes to the same ICN to be unique claims.

2.0. THE PURPOSE OF CLAIM SETS IN THE *DCS*

The primary purpose of creating claim sets is to establish a method by which potential duplicate claims are linked together. Claim sets are the distinguishing unit of categorization in the *DCS*. They identify a unique grouping of claims and line items that meet one or more match criteria and therefore are potential duplicates. Each claim set contains at least two claims. Each claim set is identified by:

- A Set Number
- A Status Code
- A Match Type
- An Owner FI
- An Owner Region

Each set also maintains totals of recoupment activities completed to date. Specifically, the set contains totals of the amounts identified for recoupment, totals of the amounts actually recouped, and totals of the allowed amounts of adjustment and cancellation HCSRs.

A claim set provides descriptive data about the claims in the set and the status of the set as it moves through the claim set life cycle to final resolution. HCSR data such as the ICN, HCSR Suffix, *PTC* date, sponsor SSAN, and other patient, provider and service data are displayed for each claim. Claim sets also contain fields that require contractor entry of data to resolve the set.

3.0. THE CLAIM SET LIFE CYCLE

The DCS is comprised of three databases. The first is the *DCS* Load *d*atabase where the HCSR extracts are processed for "loading" into the DCS Active *d*atabase. The second is *DCS* Active *d*atabase and the third is the *DCS* History *d*atabase. Sets are worked in the Active *d*atabase. Sets that have met certain criteria and that have resided in the Active *d*atabase for specified periods of time are archived to the History *d*atabase. See Chapter 9, Section 3, paragraph 1.0. and paragraphs 4.3., 4.4., and 7.0. for details regarding the *DCS* History *d*atabase. See Chapter 9, Section 3, paragraph 1.0. for information regarding the DCS Load *d*atabase.

The claim set life cycle is the foundation of the *DCS*. Claim sets in the *DCS* are given a claim set life cycle stage, i.e., a set status, to manage the resolution process. The claim set life cycle tracks each claim set as it moves through the resolution process.

In order to resolve a claim set, the contractor must identify actual duplicate claims payments, recoup the overpayments and remove duplicate conditions from the HCSR database. Or, the contractor must explain why the claims identified as potential duplicates

are not actual duplicates (e.g., twins who have received identical services). Additionally, a claim set may contain claims that are in fact actual duplicates yet none or only a portion of the monies identified for recoupment can be collected. In cases such as these, the system allows the contractor to resolve the claim set provided that an explanation for the absent or reduced recoupment is provided. The system has internal controls to ensure that the resolution process includes appropriate contractor action to fully or partially correct the duplicate condition in the HCSR database.

The claim set life cycle is composed of four stages. Each stage signifies a set status. The *Open* and *Pending* stages are considered "working" stages. Claim sets with an *Open* or *Pending* status have not been resolved. The *Closed* and *Validate* stages are considered "resolved" stages. Claim sets in the *Closed* or *Validate* status have been resolved and the appropriate rules of resolution satisfied. The four claim set life cycle stages are described below:

3.1. The Open Stage Of The Claim Set Life Cycle

This stage is the first stage in the claim set life cycle. The *Open* status is given to all claim sets when they are initially loaded into the *DCS* Active *d*atabase. In this stage, claim sets are shown with a status of *Open*, meaning that the claim set has not been researched by the contractor to determine:

- If actual duplicate payments were made on any of the claims in the set;
- The reason why a duplicate payment was made or why the apparent duplicate is not a duplicate; and
- The amount identified for recoupment, where applicable.

3.2. The Pending Stage Of The Claim Set Life Cycle

Normally, this is the second stage in the claim set life cycle. A set in *Pending* status means that the set is "Pending Recoupment". This status indicates that the contractor has completed the necessary research to determine which claims are actual duplicates and which claims are non-duplicates. At least one claim in the set must be an actual duplicate in order for the set to be in the *Pending* status. Additionally, all actual duplicates must have an amount identified for recoupment.

3.3. The Closed Stage Of The Claim Set Life Cycle

This stage is considered the final stage in the claim set life cycle. It indicates that the claim set has met all of the criteria for the set to be fully resolved. The *Closed* status means that:

- All actual duplicate claims in the set have been identified with an amount identified for recoupment;
- All claims in the set have reason codes assigned;
- The full amount entered in the amount identified for recoupment was received in offsets or refunds; and
- Adjustments were submitted that reflect the recoupments and correct the duplicate conditions on the HCSR database.

A set also can be *Closed* when all claims in the set are identified as non-duplicates.

3.4. The Validate Stage Of The Claim Set Life Cycle

This stage in the claim set life cycle is a final, but conditional, stage. It indicates that the set did not meet the rules of resolution for fully resolving the set. For example, if only 80% of the amount identified for recoupment was collected, the system will not allow the set to be *Closed*. *Validate* status means that the full amount identified for recoupment could not be recovered and the reasons and circumstances for the reduced recoupment amount have been explained and that the contractor has "validated" that required recoupment procedures for uncollected debts have been followed. By having a separate status for sets involving incomplete recovery of identified recoupments, contractors and the TMA can readily identify the involved sets and claims within the *DCS*. *Validate* status means that:

- All actual duplicate claims in the set have an amount identified for recoupment;
- All claims in the set have reason codes assigned;
- The actual amounts recouped by refund or offset have been entered and that less than 100% of the amount identified for recoupment has been collected;
- An explanation for the lower recoupment amount has been entered;
- The HCSR database has been updated to reflect any refunds received or offsets taken; and
- Required recoupment procedures have been followed as they relate to uncollected debts. The explanation entered into the system must include the user's name, the date, and the reason for the lower recoupment amount.

The *Validate* status is also used in one other circumstance. When the amount actually recouped is $10.00 or less and the contractor chooses not to submit a HCSR adjustment, an explanation must be entered to that effect, and then the set can be resolved to a *Validate* status.

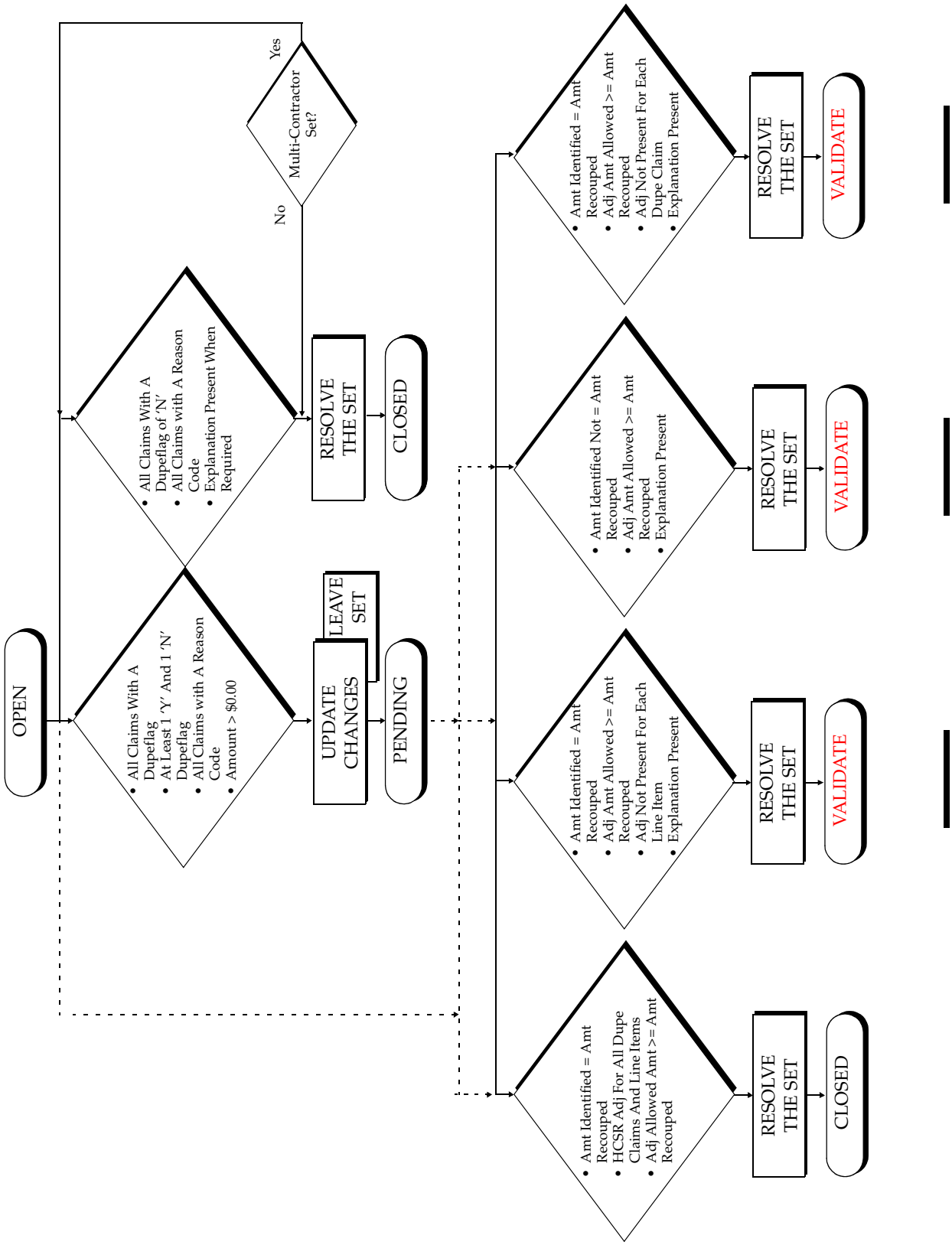
4.0. EXAMPLES OF SETS AT EACH STAGE OF THE CLAIM SET LIFE CYCLE

Each claim set has a status (e.g., *Open*) that corresponds to a stage of the claim set life cycle. The rules of resolution determine which status is given to each set. Figure 9-4-1, is a flow diagram of the rules of resolution. It shows how the rules of resolution dictate changes to claim set status.

The status of a set changes as the user enters data in five fields:

- The **Dupe?** field
- The **Reason Code** field
- The **Identified Recoup** field
- The **Actual Recoup** field
- The **HCSR Adjust?** field

FIGURE 9-4-1 RULES OF RESOLUTION

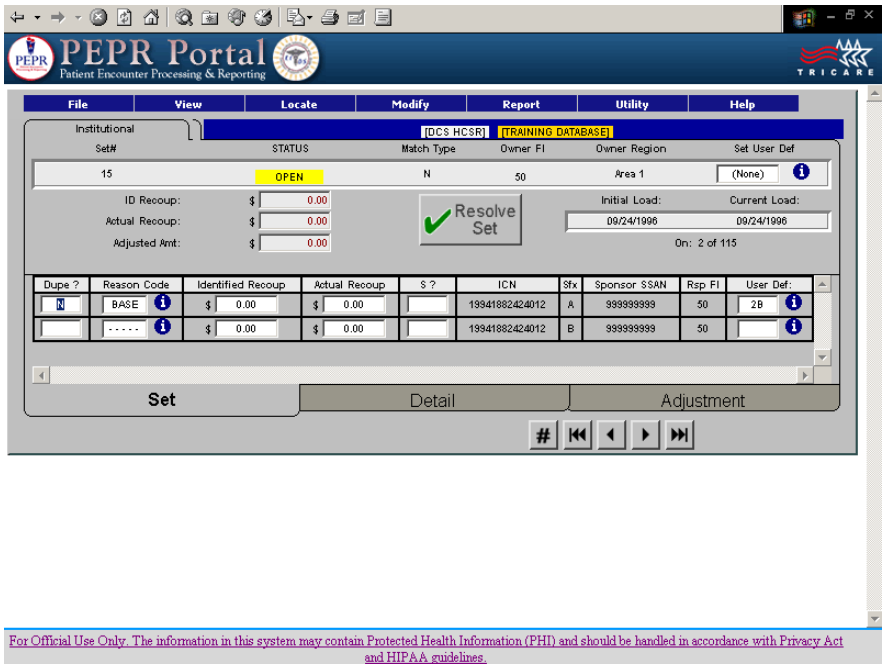


4.1. Open Claim Sets

This status indicates that the claim has not met the conditions defined in the rules of resolution for any other stage in the claim set life cycle. Essentially, *Open* claim sets are awaiting research by the contractor and subsequent action in the *DCS*.

An example of a claim set with an *Open* status is shown in Figure 9-4-2. As shown in this figure, the contractor has not entered any data in the user-controlled fields of this set (e.g., **Dupe?**, **Reason Code**, **Identified Recoup**).

FIGURE 9-4-2 SAMPLE OPEN SET

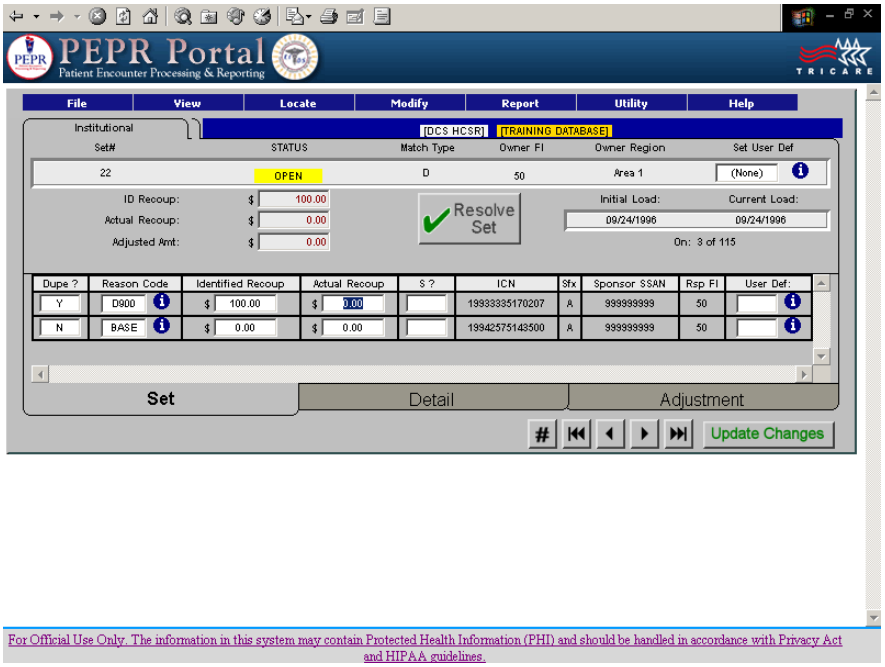


To move a set out of *Open* status, the user must enter data and invoke the rules of resolution. The user can invoke the rules of resolution by clicking the **UPDATE CHANGES** button to see if the status can be changed to *Pending*. The user also can invoke the rules of resolution by clicking the **RESOLVE THE SET** button to see if the status can be changed to *Closed* or *Validate*.

4.2. Pending Claim Sets

The status of a claim set can be changed from *Open* to *Pending* when a contractor completes the research and determines that the set contains one or more duplicates. After entering a 'Y' in the **Dupe?** field for each duplicate *(Figure 9-4-3)*, identifying the reason for each duplicate, and identifying the amount that should be recouped for each duplicate, the contractor can invoke the rules of resolution to determine if the status of the set can be changed to *Pending*.

FIGURE 9-4-3 OPEN TO PENDING CLAIM SET



In order for the status of a claim set to be changed from *Open* to *Pending*, the contractor must either click the **UPDATE CHANGES** button or leave the claim set and allow the system to make the change. In either case, the system checks for the following conditions:

- All **Dupe?** fields have a 'Y' or 'N'
- There is at least one 'Y' and one 'N'
- There is one BASE claim
- All claims have a reason code
- All 'Y' claims have an amount identified for recoupment greater than $0.00. *(If multi-FI set, see Section 6, paragraph 2.4.)*

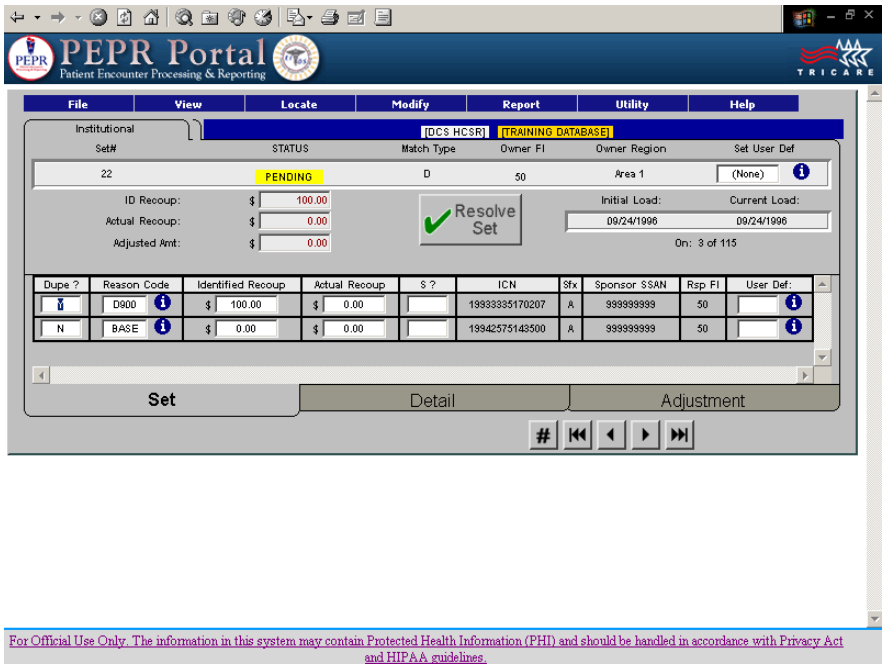
*To save changes, click the **UPDATE CHANGES** button. For an example of the UPDATE CHANGES SCREEN, see Figure 9-4-4. The following options are available:*

- *"Yes" to save all changes.*
- *"No" to rollback all changes.*
- *"Cancel" to quit.*

FIGURE 9-4-4 *UPDATE CHANGES SCREEN*

An example of a *Pending* claim set is shown in *Figure 9-4-5*. Contractors should not initiate recoupment action on an actual duplicate claim until the set has been moved to *Pending* status.

FIGURE 9-4-5 **SAMPLE PENDING SET**

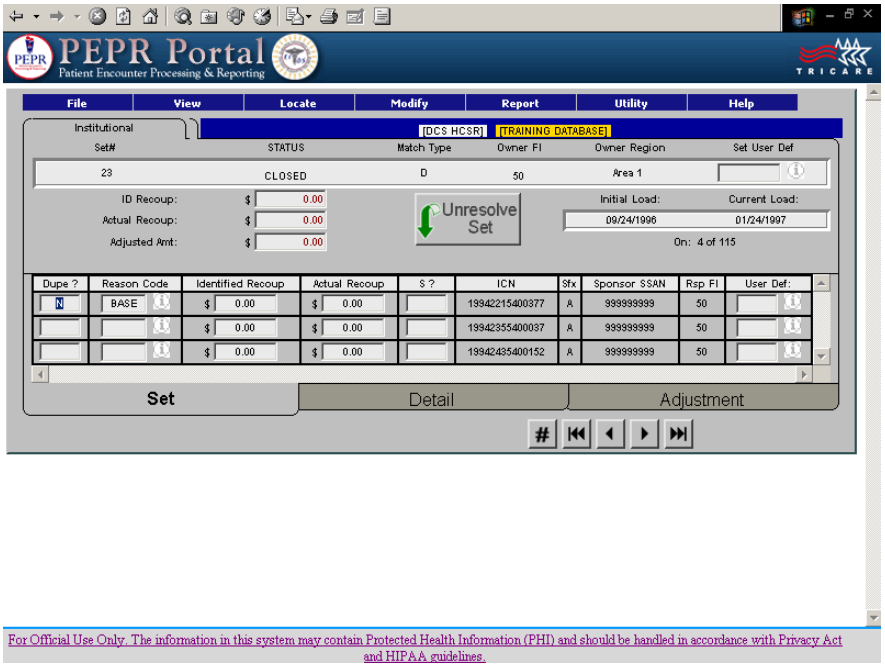


Because the **UPDATE CHANGES** button activates code that determines if a claim set meets the conditions for a *Pending* status, it also can be clicked to change the status from *Pending* back to *Open* when the *Pending* conditions are no longer met.

4.3. Closed Claim Sets

This status indicates that the claim set has met the conditions defined in the rules of resolution for full resolution. These conditions require full recoupment of all actual duplicate payments identified in the claim set. Also, HCSR adjustments corresponding to the amounts actually recouped must be flagged. If the *single contractor* set does not contain any actual duplicates, it can be resolved to a *Closed* status provided that each claim has a 'N' in the **Dupe?** field, a valid reason code and, if required, an explanation. *If it is a multi-contractor set, it must contain at least one claim with a 'Y' in the* ***Dupe?*** *field.*

FIGURE 9-4-6 SAMPLE CLOSED SET



An example of a claim set in *Closed* status is shown in *Figure 9-4-6*. As described in Chapter 9, Section 2, paragraph 5.3., the **RESOLVE THE SET** button must be clicked to change the status of a claim set to *Closed*. Before this action, the status of the set may be *Open* or *Pending*. To meet the conditions for changing the status to *Closed* when one or more actual duplicates have been identified, the following conditions must be met:

- All **Dupe?** fields must have a 'Y' or 'N'.
- There must be at least one 'Y' and one 'N' in the set.
- All claims must have a valid reason code (some reason codes require a free-text explanation).
- The total amount identified for recoupment must be greater than $0.00.

- The total amount identified for recoupment must equal the total amount actually recouped.
- The total HCSR adjustment allowed amounts flagged must be equal to or greater than the total amount actually recouped.
- Every duplicate claim and every duplicate line item must have a corresponding HCSR adjustment.

If no actual duplicates have been identified in a set, the following conditions must be met to change the status to *Closed*:

- All claims in the set must have a 'N' in the **Dupe?** field.
- All claims in the set must have a valid 'N' reason code.
- All **Identified Recoup** and **Actual Recoup** fields must equal $0.00.

Closed claim sets remain on the DCS Active *d*atabase for two years, at which time they are moved to the DCS History *d*atabase where they are kept for an additional seven years. The system does not allow users to modify any of the fields in a *Closed* set unless the set is "unresolved" (i.e., moved back to the *Open* or *Pending* status by clicking the **UNRESOLVE THE SET** button). *Closed* sets in the DCS History *d*atabase are deleted after seven years.

4.4. Validate Claim Sets

This status indicates that the claim set has been resolved but the resolution did not meet the *Closed* status conditions, i.e., the full amount was not refunded or offset. The set may meet one of the four conditions for changing the status to *Validate*, as shown in *Figure 9-4-7*.

FIGURE 9-4-7 CONDITIONS FOR CHANGING CLAIM SET STATUS TO VALIDATE

CONDITION 1	CONDITION 2	CONDITION 3	CONDITION 4
The total amount identified for recoupment is not equal to the total amount actually recouped.	The total amount identified for recoupment is equal to the total amount actually recouped.	The total amount identified for recoupment is equal to the total amount actually recouped.	The total amount recouped is less than or equal to $10.00.
and	**and**	**and**	**and**
The sum of the allowed amount(s) for all selected adjustments is greater than or equal to the total amount actually recouped.	The sum of the allowed amount(s) for all selected adjustments is greater than or equal to the total amount actually recouped.	The sum of the allowed amount(s) for all selected adjustments is equal to or greater than the total amount actually recouped.	No adjustment was submitted by the contractor for the $10.00 or less recoupment.

FIGURE 9-4-7 CONDITIONS FOR CHANGING CLAIM SET STATUS TO VALIDATE (CONTINUED)

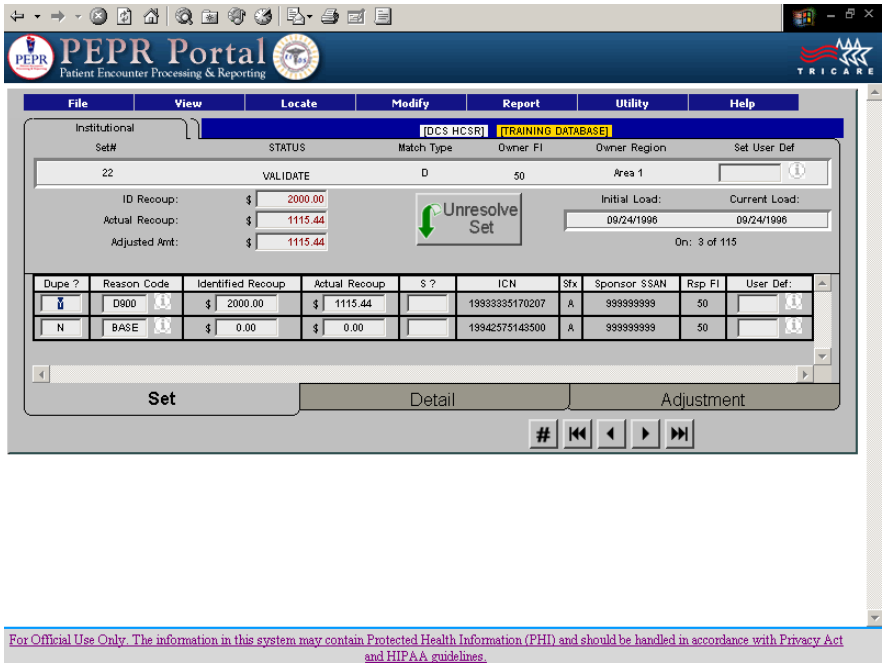
CONDITION 1	CONDITION 2	CONDITION 3	CONDITION 4
and	**and**	**and**	**and**
The user enters an explanation for the discrepancy in the total amount identified for recoupment and the total amount actually recouped.	There is not a selected adjustment for every claim with a **Dupe?** of 'Y'.	There is at least one selected adjustment for every claim with a **Dupe?** of 'Y'.	The user enters an explanation that no HCSR adjustment will be submitted for a refund of $10.00 or less.
	and	**and**	
	The user enters an explanation for the discrepancy in the number of adjustments flagged and the number of claims with a **Dupe?** of 'Y'.	There is not a selected adjustment for every line item in every non-institutional claim with a **Dupe?** of 'Y'.	
		and	
		The user enters an explanation for the discrepancy in the adjustment line items flagged and the line items with a **Dupe?** of 'Y'.	

An example of a claim set with a *Validate* status is shown in *Figure 9-4-8*. As shown in this figure, the sum of the amount identified for recoupment, the sum of the amount actually recouped, and the sum of the associated HCSR adjustment allowed amounts satisfy condition 1 for changing the status to *Validate*.

When a user clicks the **RESOLVE** button to resolve a set that does not meet the full recoupment conditions required to change the status to *Closed*, the system will present the user with the condition(s) under which full recoupment requirements were not met. The system will then prompt the user to continue with resolution. If the user elects to continue and the set meets one of the *Validate* conditions, the system will display a pop-up screen requesting an explanation for the *Validate* status. The user is required to type in their name, the date, and explanation for the *Validate* situation.

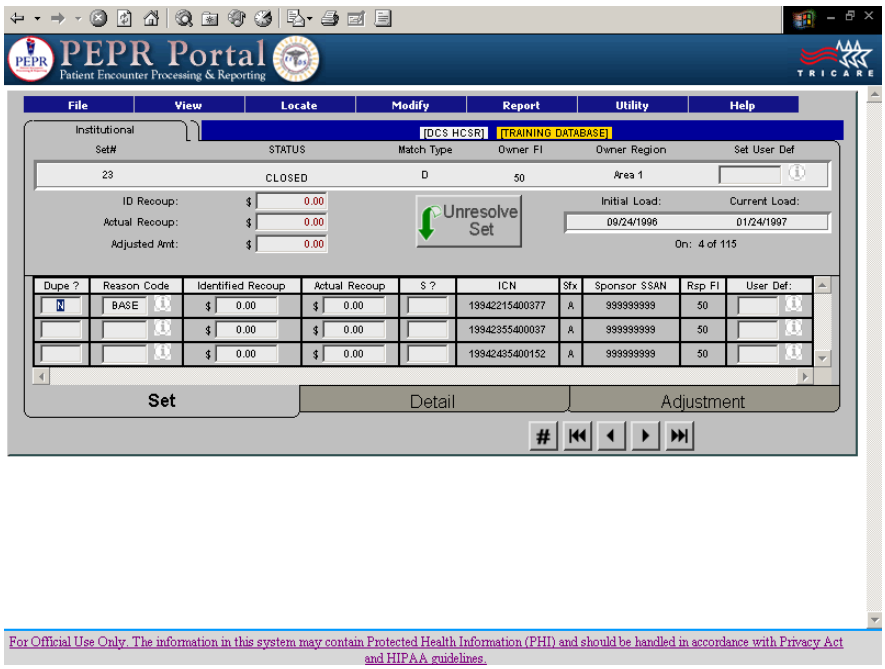
Validate claim sets remain on the DCS Active *d*atabase for five years, at which time they are moved to the DCS History *d*atabase where they are kept for an additional seven years. The system does not allow users to modify any of the fields in a *Validate* set unless the set is "unresolved" (i.e., moved to an *Open* or *Pending* status by clicking the **UNRESOLVE SET** button). *Validate* sets in the DCS History *d*atabase are deleted after seven years.

FIGURE 9-4-8 SAMPLE VALIDATE SET



It should be noted that any *Closed* or *Validate* set may be moved from *Closed* or *Validate* status back to a *Pending* or *Open* status in the DCS Active *d*atabase by clicking the **UNRESOLVE SET** button *(Figure 9-4-9)*. It should also be noted that if a new potential duplicate claim is identified which belongs in a *Closed* or *Validate* set residing in the DCS Active *d*atabase, the system will add the new potential duplicate to the *Closed* or *Validate* set and change the status of the set to *Open* or *Pending*.

FIGURE 9-4-9 UNRESOLVE SET



5.0. APPENDING NEW CLAIMS TO EXISTING SETS DURING THE MONTHLY EXTRACT CYCLE

During each monthly extract cycle, new claim sets are added to the *DCS* Active *d*atabase. At the same time, if a new claim is identified as a potential duplicate of a claim in an existing set, it is added to the existing set. These sets are called appended sets. As the system appends these new claims to their appropriate sets, the system determines if the current **Owner FI** should be changed. It also determines if the status of the set should be changed.

5.1. Determining The Owner FI Of Appended Sets

The system applies the general rule of assigning the **Owner FI** to the **Responsible FI** of the claim with the latest PTC date if the status of the set is *Open* or *Closed*. If the status of the set is *Pending* or *Validate*, the system ignores this rule and leaves the current assignment of the **Owner FI**.

5.2. Determining The Status Of Appended Sets

All single contractor appended sets become *Open* sets. All multi-contractor appended sets are moved out of a resolved status (i.e., *Closed* or *Validate*) to a working status (i.e., *Open* or *Pending*). For multi-contractor appended sets, the following changes are applied:

- Appended sets in a *Closed* status are changed to *Open* status.
- Appended sets in a *Validate* status are changed to *Pending* status.
- Appended sets in a *Pending* status remain *Pending* sets.
- Appended sets in an *Open* status remain *Open* sets.

6.0. LOAD DATES

The *DCS* assigns two Load Dates (**Initial Load Date** and **Current Load Date**) to each set when loaded to the DCS. When a set is first loaded, both the **Initial Load Date** and the **Current Load Date** are the same. The **Initial Load Date** remains unchanged throughout the life cycle of the set. The **Current Load Date**, which is used in calculating compliance with the performance standards for the DCS (see *Section 9, paragraph 8.0.*), may change. There are two circumstances under which the **Current Load Date** could change. These circumstances are:

- When the **Owner FI** changes.
- When a set is appended with a new claim.

7.0. HISTORY DATABASE

The *DCS* History *d*atabase contains sets that had been in the DCS Active *d*atabase in *Closed* or *Validate* status for either two or five years respectively. The data in the History *d*atabase is read only. While users cannot change any data in the History *d*atabase, they can run reports. Certain TMA and contractor users have permission to "Unarchive" a set in the History *d*atabase (i.e., move the set back to the DCS Active *d*atabase where changes may be made. (See *Section 2, paragraph 1.0.*, for instructions for accessing the History *d*atabase.)

USER'S GUIDE

This section is a detailed user's guide to essential system functions. It provides examples to illustrate system capabilities and describes how users can access the system appropriately. Although it contains information that appears in other sections of this document, this section particularly focuses on user screens and functions designed to resolve duplicate claim sets.

1.0. AUTHORIZED USERS

The Duplicate Claims System *(DCS)* distinguishes among three groups of users:

- Contractors are the primary users. They have read/write access to the data. They use the system to resolve claim sets by viewing potential duplicate claims, identifying actual duplicates, and monitoring recoupment activities.
- *TRICARE Management Activity (*TMA*)*/Government personnel access the system to monitor duplicate claims resolution activities, generate management reports, and evaluate contractor performance. These users have read-only access to the system.
- The third group of users are a very limited number of TMA staff who have read/write access to the system.

1.1. Contractor Users

Contractor users have read/write access to the data. Certain contractor users have additional permissions to perform functions within the DCS that are not available to all contractor users. Such functions include establishing claim and set level user defined codes and returning archived sets to the production database. Contractors are required to use the system. Each contractor has limited access to the claim sets in the database. In general, this means that contractors have access only to their own claim sets, i.e., sets containing claims they processed or inherited from a previous contractor during a transition. The system uses the **Owner FI** field to maintain this control of sets. The system uses two other fields to refer to a specific contractor. These fields are discussed below:

1.1.1. Processing FI

This field refers to the contractor who processed the claim and submitted the associated *Health Care Service Record (*HCSR*)*. This field never changes.

1.1.2. Responsible FI

This field refers to the contractor who currently is responsible for a specific claim in a claim set. In most instances, the Responsible FI will be the contractor who processed the claim. However, if the Processing FI is no longer responsible for this claim (e.g., due to a contractor transition), the Responsible FI will be a different contractor. A contractor cannot change the Responsible FI (**Rsp FI**) field.

(See *Section 7,* for an explanation of how the system uses the mass change function to reassign the Responsible FI for existing claims in the system following a change in contractors.)

1.1.3. Owner FI

The **Owner FI** identifies the contractor responsible for (i.e., "owns") a set. Initially, the **Owner FI** is assigned by the system during the loading of the claim set. The system looks at all of the claims in the set and selects the contractor who submitted the claim with the most recent processed to completion *(PTC)* date. In most instances, a single contractor will have submitted all the claims in the claim set so the **Owner FI** will be the same as the Responsible FI on the claims. However, if more than one contractor processed and submitted the claims in a set, the system determines which contractor submitted the claim with the latest *PTC* date. This contractor is designated as the **Owner FI** and becomes responsible for the resolution or transfer of the claim set. Under certain circumstances during a contractor transition or during the resolution of a multi-contractor claim set, the **Owner FI** may change. See Sections 6 and 7, for additional details.

1.2. TMA/Government Users

The TMA is responsible for a number of contract administration and evaluation activities, including the monitoring of contractor duplicate claim resolution activities. TMA personnel use the *DCS* to generate management reports and monitor contractor performance. The TMA will audit claim sets in the various stages of the claim set life cycle. For example, *Validate* claim sets may be periodically audited to verify that complete refunds of identified recoupment amounts could not be collected and that required recoupment procedures had been followed. *Closed* claim sets containing non-duplicates may be audited to verify that all of the claims in the set were not duplicates. *Pending* claim sets may be audited to verify compliance with recoupment requirements and timeliness standards.

The *DCS* provides the TMA with the capability to audit contractors for compliance with system requirements governing "ownership" transfers of multi-contractor sets, the selection of accurate and appropriate reason codes, and the adequacy of the explanations entered into the system for any of the above. In short, any and all aspects of using the *DCS*, its data, and its output are subject to audit by TMA or other Government auditing personnel. The TMA is also responsible for initiating data administration and system maintenance activities associated with extracting and loading HCSRs to the *DCS* and for performing mass change functions for contractor transitions.

1.3. Selected TMA Personnel

A limited number of TMA personnel have read/write access to the system. These personnel use their read/write access for system and data integrity management purposes.

2.0. REQUIREMENTS FOR ACCESSING THE SYSTEM

User access to the system is controlled by security procedures that require an individual to have access to the Government's servers and the *DCS*. Security procedures require a valid user ID and password.

2.1. User ID And Password

A critical component of system security is the assignment of unique user identification numbers (IDs) and passwords for each individual authorized to access the system.

Individual users at contractor and TMA sites have the capability to define their own passwords for accessing the *DCS*. Users can change these passwords at *the* time *of log on to the Patient Encounter Processing and Reporting (PEPR) Portal.*

As previously stated, the system allows access to those functions authorized and associated with particular user IDs. For example, contractors are permitted access only to those potential duplicate claim sets for which they are the **Owner FI**. Also, they are permitted to generate reports based only upon their own data. The same restriction to accessing data applies to the downloading function. TMA users are authorized to access claim sets for any and all contractors. Additionally, they have access to a number of administrative functions, such as generating management reports containing the aging of claims data in the aggregate, by region, or by specific contractor.

2.2. Signing On To The System

After a user has *agreed to* the *PRIVACY ACT* SCREEN, user log-on is directed by a screen that queries the user for an ID and password. The User ID determines what level of access is permitted and what data (claim sets) can be viewed. Once a valid User ID and password are entered, *the user* is connected to the *DCS*.

The claim set life cycle and the resolution of duplicate claim sets begin when contractors sign on to the *DCS* to view and examine potential duplicate claims (see *Section 3, paragraph 2.0.,* for a description of the claims selection criteria). Through menus, contractors can define parameters to create a filter for the types of claim sets they want to view (see paragraph 4.1.2., for details regarding the **V**iew function).

2.3. Accessing Claims Data

The *DCS* uses the **Owner FI** field to identify and limit access to claims data. The **Owner FI** is responsible for resolving the claim set. The system allows only the **Owner FI** to view the claim set and enter data to resolve the set. The **Owner FI** is solely responsible for

researching and resolving the claim set. No other contractor can view or access a claim set owned by another contractor.

3.0. USER SCREENS

Four user screens display HCSR data, permit users to enter resolution data, and provide feedback to users on the rules of resolution.

3.1. Becoming Familiar With The Screens

3.1.1. Each claim set uses multiple screens to display data. To access the different screens, users click on tabs. All sets have a CLAIM SET SCREEN and a CLAIM DETAIL SCREEN. If the set is composed of non-institutional claims, it also has a LINE ITEM DETAIL SCREEN. If the set has associated HCSR adjustments, the set also has an ADJUSTMENT DETAIL SCREEN.

3.1.2. Normally, the first screen to be displayed will be the CLAIM SET SCREEN. This screen reflects the current date and labels the set as either an institutional or non-institutional set. The top section of the screen contains the menu bar for initiating a number of user functions. Below the menu bar, in the upper portion of the screen, are the *S*et *N*umber, *S*tatus, *M*atch *T*ype, *O*wner FI, *O*wner *R*egion, and *S*et *L*evel *U*ser *D*efined *C*ode fields. Totals of individual claim recoupment amounts are also displayed in the upper section. In the lower portion of the screen, claim-level data extracted from HCSRs are displayed. The lower portion also contains fields for indicating which claims are duplicates, reason codes, the amounts to be recouped*, and the amounts actually recouped* for each duplicate claim. In addition, fields for entering claim level user defined codes are available as well as a "solicited" field that may be used to distinguish duplicates for which refunds must be solicited from those for which only a HCSR adjustment *is* required.

3.1.3. At the bottom of the CLAIM SET SCREEN is a **Detail** tab which allows the user to move to the CLAIM DETAIL SCREEN. Once in the CLAIM DETAIL SCREEN, the user can click on a **Set** tab to move back to the CLAIM SET SCREEN.

3.1.4. The top portion of the CLAIM DETAIL SCREEN contains set information. Below the set information, claim-level detailed data are displayed. Note that left and right arrows and a scroll bar appear on the bottom of the data box to allow the user to scroll through this data. Approximately 50 claim-level fields are shown for each claim.

3.1.5. If a claim set contains non-institutional claims, there will be a **Line Item** tab at the bottom of the CLAIM SET SCREEN and the CLAIM DETAIL SCREEN to allow the user to move to the LINE ITEM DETAIL SCREEN.

3.1.6. Note that the LINE ITEM DETAIL SCREEN has a sort function above the line item data fields. The *white highlighted* **Unsorted** *button to the right of the tab,* indicates that the display is in *Internal Control Number (*ICN*)* order (i.e., all line items from one claim are shown before the next claim's line items). If the display contains more than two line items, it may be helpful to sort the display by grouping matched line items. To sort the line items by procedure code, the user clicks *on* the ***SORTED*** *button to the left of the* ***UNSORTED*** *button*.

3.1.7. If a claim set has any adjustments corresponding to institutional claims or non-institutional line items, there will be an **Adjustment** tab at the bottom of all screens. This tab allows the user to move to the ADJUSTMENT SCREEN.

3.1.8. The bottom portion of the ADJUSTMENT SCREEN displays data for each adjusted claim. A vertical scroll bar will appear when appropriate to allow the user to view additional adjustments. Like all DCS system screens, the ADJUSTMENT SCREEN displays HCSR data. Adjustment data displayed includes claim ICN and suffix, HCSR line item and procedure code, and the allowed amount of the adjustment (not to be confused with the Government paid amount).

3.1.9. All screens were designed to display relevant information to facilitate set resolution. Note that claims data is color-coded so that:

3.1.9.1. Extracted data from the HCSR database and claim-specific data created by the system appear in black.

3.1.9.2. The total amounts calculated by the system appear in red.

3.1.9.3. Data in user-controlled fields appear in blue or green.

3.1.9.4. ICNs which represent claims in multiple sets appear in white on the CLAIM SET SCREEN.

As explained in the preceding paragraphs, user screens have been designed to display claims data and associated adjustments and also provide for user entry of information needed to resolve the set. User screens also display information about the set, showing the *S*et *N*umber, *S*et *S*tatus, *M*atch *T*ype, Owner FI, and Owner Region.

All screens display ***VCR*** movement buttons on the bottom of the screen to enable a user to move to another screen of the same set or to move to the first, next, previous, last, or a user designated set contained within the contractor's full or restricted "view." A contractor will have full view of all the sets for which the contractor has been assigned as the **Owner FI** if no restricted views (via the **V**iew function of the menu bar) have been set by the contractor. If, however, the contractor uses the **V**iew function to request a restricted view of, for example, only *Pending* institutional sets with an exact match, the contractor will see only those sets. (See paragraph 4.1.2., for a description of the **V**iew function of the menu bar.)

There are four screens that display information about a set:

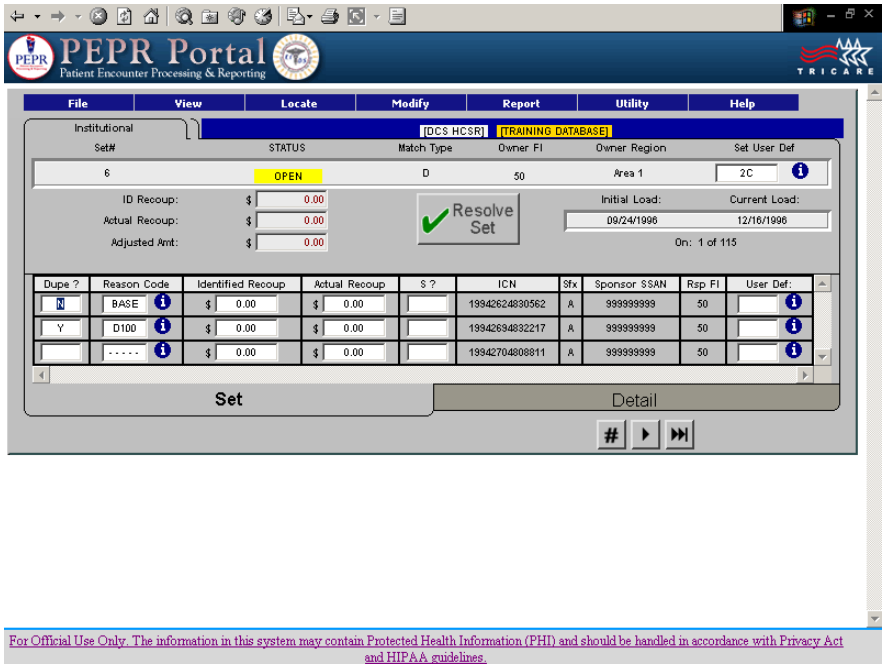
- CLAIM SET SCREEN
- CLAIM DETAIL SCREEN
- LINE ITEM DETAIL SCREEN (Non-institutional sets only)
- ADJUSTMENT SCREEN (Sets with adjustments)

3.2. Claim Set Screen

3.2.1. Set-Level Portion Of The Claim Set Screen

The CLAIM SET SCREEN displays general information about the claim set and the individual claims within the set. It is considered to be the first screen in each set. As shown in Figure 9-5-1, this screen displays system-calculated totals of the amount identified for recoupment, amount actually recouped, and the adjustment amount. Note that these totals are calculated from the entries the user made in the claim level portion of the screen. The screen also displays the *S*et *N*umber, the *S*et *S*tatus, the *S*et *M*atch *T*ype, the *O*wner FI, and the *O*wner *R*egion. It also displays the initial and current load dates and the set count of the current set versus the total number of sets in the contractor's full or restricted view of the sets, e.g., "53 of 3333", meaning the current set is the 53rd set of a total of 3,333 sets in the current view.

FIGURE 9-5-1 SAMPLE CLAIM SET SCREEN



3.2.2. Set Level User Defined Field

The upper portion of the screen also contains the **Set User Def** field. This field permits users to enter a user defined code to label the set to reflect additional information that the contractor wishes to track or to have available. While users may enter a user defined code, only certain contractor users have permission to define, activate, or de-activate the codes that may be used. User defined codes may be one or two characters in length. (See paragraph 4.2.1. for additional information.)

3.2.3. RESOLVE And UNRESOLVE Buttons

The screen also contains the **RESOLVE THE SET** button if the set is in *Open* or *Pending* status or the **UNRESOLVE THE SET** button if the set is in *Closed* or *Validate* status.

3.2.4. Set Recoupment Amounts

As noted above, the system-calculated totals of the amounts identified for recoupment, amounts actually recouped, and adjustment amounts for this set are based on the entries made by the user in the claim-level portion of this screen and the ADJUSTMENT SCREEN.

3.2.5. Claim Level Portion Of The Claim Set Screen

The claim level portion of the CLAIM SET SCREEN has headers that read: **Dupe?**, **Reason Code**, **Identified Recoup**, **Actual Recoup**, **S?**, **ICN**, **Sfx**, ***Time Stamp,*** **Sponsor SSAN**, **Rsp FI**, and **User Def:**. Of these *10* fields, six are designated as user entry fields and four are designated as read-only HCSR data fields. Specifically, the user-entry fields provide for entry of a 'Y' or 'N' in the **Dupe?** field to indicate if the claim is an actual duplicate payment or a non-duplicate, along with a valid reason code to explain why this determination was made. It also provides for user entry of specific claim recoupment activity to indicate the amount identified for recoupment and the amount actually recouped for each claim identified as an actual duplicate payment. The **Dupe?**, **Reason Code**, **Identified Recoup**, and **Actual Recoup** fields are required fields (when appropriate). The **S?** (Solicited Indicator) and the **User Def:** (User Defined Code) fields are optional.

3.2.6. Claim Level Data

The fields in the claim level data portion of the CLAIM SET SCREEN are described below:

- **Dupe?** (Dupeflag) - must be 'Y' for an actual duplicate or 'N' for a non-duplicate
- **Reason Code** - must be a valid reason code for the 'Y' condition (e.g., erroneous dupe override, jurisdictional error) or the 'N' condition (e.g., twins, different service)
- **Identified Recoup** - amount identified for recoupment
- **Actual Recoup** - amount actually recouped
- **S?** - Solicited Indicator. An optional use field that may be used to distinguish duplicate claims for which refunds must be initiated (solicited) as opposed to those for which refunds have been received without recoupment efforts (unsolicited refunds) or received but for which no HCSR adjustments have been submitted.) A user may enter a 'Y', an 'N', or leave the field blank. (See paragraph 4.2.3. for additional information.)

- **ICN** - the *Internal Control N*umber
- **Sfx** - HCSR suffix
- ***Time Stamp*** *- the claim time stamp*
- **Sponsor SSAN** - sponsor Social Security Account Number
- **Rsp FI** - The contractor responsible for this claim (either the Processing FI who remains currently responsible for correcting any errors associated with the claim or another contractor who, as a result of a contractor transition, is currently responsible for this claim). The Responsible FI for each claim may or may not be the same as the **Owner FI**. Refer to paragraph 1.1., for further explanations of these fields and *Section 7,* for information regarding mass changes.
- **User Def:** - claim level user defined field. The claim level portion of the screen also contains *a* **User Def:** field. This field permits users to enter a user defined code to label a claim to reflect additional information that the contractor wishes to track or to have available. While users may enter a user defined code, only certain contractor users have permission to define, activate, or de-activate the codes that may be used. User defined codes may be one or two characters in length. (See paragraph 4.2.2. for additional information.)

It should be noted that the *DCS* defines a "claim" as an ICN plus the HCSR suffix plus a unique time stamp. This is important, since two claims with the same ICN but with different suffixes may appear as potential duplicates of each other in a claim set. This is because the *DCS* treats different suffixes of the same ICN as unique claims.

3.2.7. Action And Movement Buttons And Tabs

Each screen contains several buttons and tabs that allow a user to move from set to set and screen to screen, and also to change the status of a set.

3.2.7.1. The **RESOLVE THE SET** button allows the contractor to invoke the rules of resolution to determine if the set can be resolved to a *Closed* or *Validate* status. If the set is already resolved, the button will read "UNRESOLVE THE SET". In this situation, the button can be used to unresolve the set to a *Pending* or *Open* status.

3.2.7.2. The **UPDATE CHANGES** button allows a contractor to update the Duplicate Claims *d*atabase with newly entered data. It is a "smart" button in the sense that it only appears after new data has been entered on either screen. The status of a set may change from *Open* to *Pending* or from *Pending* to *Open* when the **UPDATE CHANGES** button is pressed depending on the newly entered data.

3.2.7.3. Screen movement tabs allow a user to navigate among the four DCS screens. For example, the **Detail** *tab* allows the user to move to the CLAIM DETAIL SCREEN. Two of the screen movement tabs will appear on every set (**Set** tab and **Detail** tab). The other two tabs will appear as appropriate. The **Line Item** tab will appear only on sets containing non-

institutional claims. The **Adjustment** tab will only appear when an adjustment has been loaded to the set. The appearance of the **Adjustment** tab notifies a user that associated adjustments exist for this set and enables the user to move to the **ADJUSTMENT SCREEN** to see them.

3.2.7.4. **VCR** buttons are shown at the bottom of all screens. They allow the user to move from one set to another set, e.g., to the previous set, to the next set, to the last set. The < button moves to the previous claim set, the > button moves to the next claim set, the |< button moves to the first claim set, and the >| button moves to the last claim set available to the user. The # button, when pressed, prompts the user to enter a specific set number. When entered and the **OK** button is pressed, the user will be taken to the set specified.

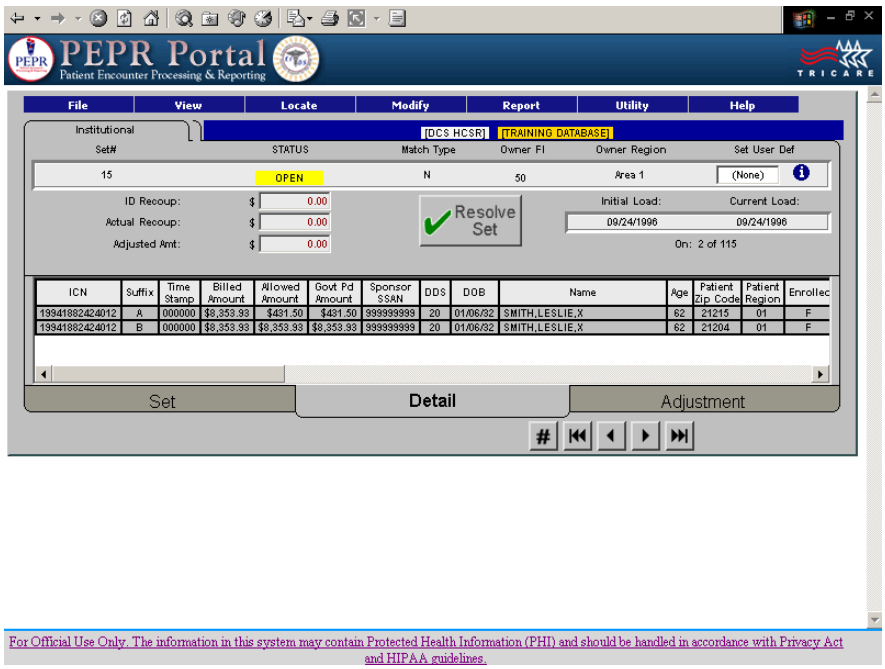
3.3. Claim Detail Screen

This screen displays additional HCSR data about each claim in the claim set. With the exception of the set level user defined field (**Set User Def**), no data may be changed and no data is entered on this screen. The data displayed is "read-only" and is provided to assist contractors in the research process. The CLAIM DETAIL SCREEN shown in Figure 9-5-2, displays 51 fields of HCSR and *DCS* data. This screen shows the following fields for institutional and non-institutional claims in a claim set:

Claim ICN
Time Stamp
Allowed Amount
Sponsor Social Security Number
Patient Date of Birth
Patient Age
Patient Region
Provider Tax ID
Provider Zip Code
Provider Specialty
Special Processing Code I
Special Processing Code III
Type of Institution Code
Institutional Care Begin Date
Diagnosis
Discharge Disposition Code
Processing FI Code
Processing Contract Number
Cycle Number
Voucher Sequence Number
Program Indicator
Risk Indicator
Duplicate Flag (**Dupe?**)
Solicited Indicator
Identified Recoupment Amount
HCSR Adjustment Allowed Amount
HCSR Suffix
Billed Amount
Government Paid Amount
DEERS Dependent Suffix
Patient Name
Patient Zip Code
Enrollment Status
Provider Sub-ID
Provider Region
Provider Affiliation Code
Special Processing Code II
Special Rate Code
Institution Admission Date
Institutional Care End Date
DRG Code
Responsible FI Code
Responsible Contract Number
PTC Date
Batch Sequence Number
Billing Frequency Code
Mass Change Level
Claim Match Type Code
Reason Code
User Code (claim level)
Actual Recoupment Amount

Because all of these fields cannot be displayed across the width of one screen, the system provides a scroll bar and left and right arrow buttons at the bottom of the window to permit viewing all of the fields available.

FIGURE 9-5-2 SAMPLE CLAIM DETAIL SCREEN



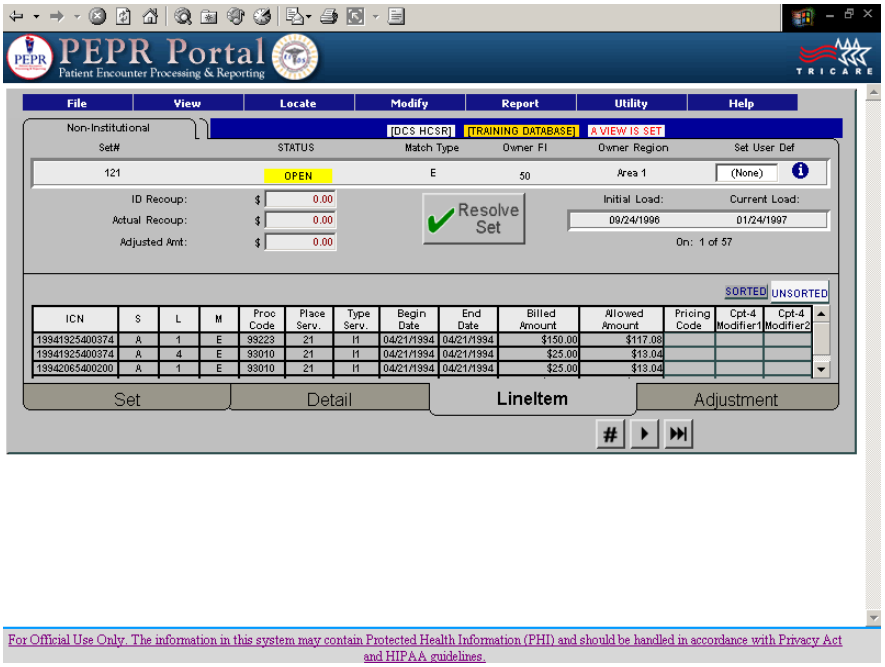
3.4. Line Item Detail Screen

This screen displays additional details about each non-institutional line item in the claim set. The LINE ITEM DETAIL SCREEN shown in Figure 9-5-3 displays, along with set information common to all screens, *14* fields containing the following line item information about each potential duplicate line item in the set:

ICN	HCSR Suffix
Line Item Number	Line Item Match Type Code
Procedure Code	Place of Service Code
Type of Service Code	Service Begin Date
Service End Date	Billed Amount
Allowed Amount	*Pricing Code*
CPT-4 Modifier 1	*CPT-4 Modifier 2*

This screen also has two buttons just above the line item information that are used for sorting (i.e., by procedure code) or for unsorting (i.e., by ICN) the line items displayed. Sorting may be helpful when there are more than two line items in the set. As with the data displayed on the CLAIM DETAIL SCREEN, the data on the LINE ITEM DETAIL SCREEN are extracted from the HCSRs and are read-only fields which cannot be modified. They are displayed in the LINE ITEM DETAIL SCREEN to provide additional information about each line item in the set in order to facilitate contractor research.

FIGURE 9-5-3 SAMPLE LINE ITEM DETAIL



3.5. Adjustment Screen

This screen displays associated HCSR adjustments for each institutional claim or non-institutional line item in the claim set. It also provides for user entry of a 'Y' or 'N' in a flag field to indicate which adjustment(s) are associated with the recoupment(s) of actual duplicate payments.

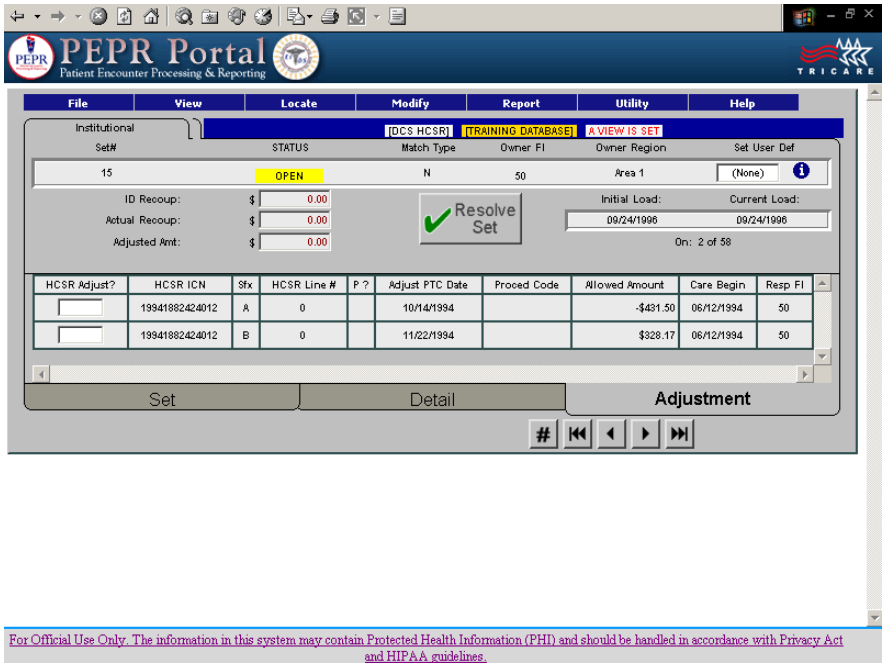
The ADJUSTMENT SCREEN displays the following HCSR data and *DCS* data fields:

HCSR Adjust Flag	*ICN*
HCSR Suffix	HCSR Line Item Number
Provisional Indicator (P?)	Adjustment PTC Date
Procedure Code	Allowed Amount
Care Begin Date	Responsible FI

An ADJUSTMENT SCREEN for an institutional claim set appears in Figure 9-5-4. The ADJUSTMENT SCREEN for non-institutional claim sets (as shown in Figure 9-5-5) also displays the appropriate HCSR line item number and associated procedure code.

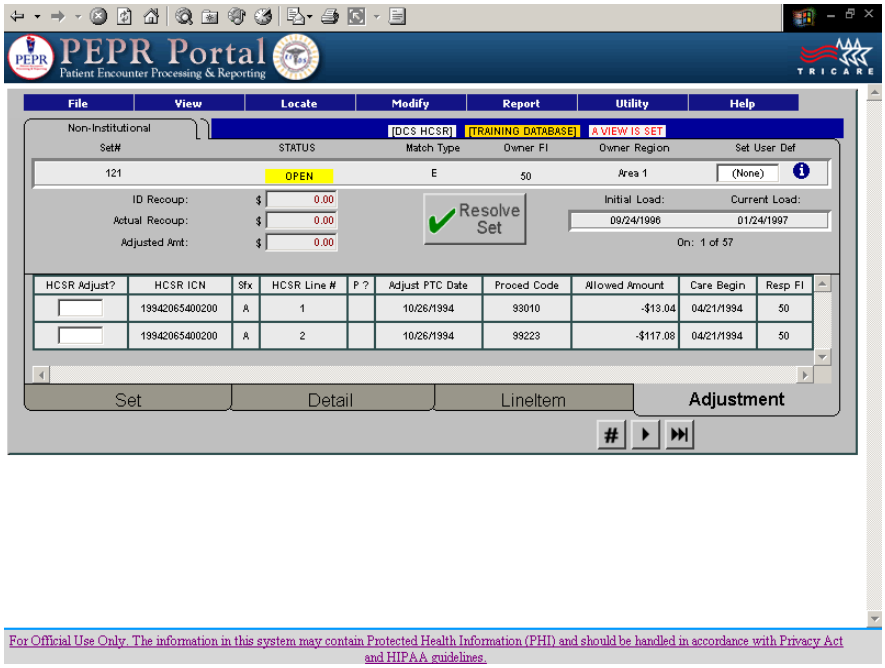
The ADJUSTMENT SCREEN displays ICNs and suffixes for all adjusted claims in the set. For each adjustment, a user can view the adjustment date, the allowed amount, and the Responsible FI. The user may enter a 'Y' in the **HCSR Adjust?** flag field to link the adjustment to an actual duplicate claim for which refunds/offsets have been received.

FIGURE 9-5-4 SAMPLE INSTITUTIONAL ADJUSTMENT SCREEN



Note that for institutional claims, the HCSR line item number will be zero and the procedure code will be blank. Also, the care begin date reflects the claim level begin date for institutional claim adjustments and the line item service date for non-institutional line item adjustments.

FIGURE 9-5-5 SAMPLE NON-INSTITUTIONAL ADJUSTMENT SCREEN



4.0. USER TOOLS FOR NAVIGATING AROUND THE SYSTEM

4.1. Menu Bar

The menu bar is at the top of each screen. The menu bar contains seven selections which can be activated by a single click of the mouse.

4.1.1. File

The **F**ile function contains *two* choices: **P**rint to generate a report containing all of the data in the current set and **E**xit to return to the ACCESS SCREEN. Users should be aware that the **P**rint choice will display a report of the data for the current set including comments and notepad entries. Where no data exists, such as line item data for an institutional set, the report will display a blank Line Item Detail section. Where no adjustment data exists, the report will display a blank Adjustment Detail section.

4.1.2. View

FIGURE 9-5-6 VIEW FUNCTION

The **V**iew function, shown in Figure 9-5-6, allows users to "**S**et a view", i.e., to restrict their view of claim sets which satisfy parameters defined by the user. Users can pick and choose the types of sets they wish to view by clicking on the various buttons appearing on the Select Data View parameter form. Some of the views users can create include:

- Only single contractor sets.
- Only multi-contractor sets.
- Sets associated with a specific region or contract.

- Only institutional or non-institutional sets.
- Sets selected by a specific match criteria (e.g., near match).
- Only sets in *Open*, *Pending*, *Validate*, or *Closed* status.
- Sets with adjustments or without adjustments.
- Only sets loaded during a specific month.
- *Only Sets with specified enrollment.*

Additional set views may be created by clicking on two or more buttons. For example, a *West* Region or TMA user could click on the appropriate buttons and view only sets in *Open* status that meet the exact match criteria for *the West* Region.

The message "A View is Set" is displayed when a user has successfully set a view to remind the user that a restrictive view is in effect. The **V**iew function also allows users to "**C**lear a view" and return to viewing all sets available for that user.

4.1.3. Locate

The **L**ocate function provides a means for quickly finding and viewing specific sets by specifying a:

- Claim Set number
- Claim ICN
- Sponsor SSAN

When the user selects **L**ocate Value from the **L**ocate menu bar, a pull-down menu appears from which the user can choose a claim set number, ICN, or sponsor SSAN. Once one of the choices is selected, the user enters the desired number in a value box and clicks the **OK** button. After a few moments, the system will display the first set meeting the criteria selected.

If a user selects a specific claim set by set number on the pull-down menu (e.g., Claim Set 25), the system will display only the set with the number "25". If a user enters a specific sponsor SSAN or ICN, there may exist other sets in the system that contain claims with the same sponsor SSAN or ICN. If multiple sets exist in the database that contain the same ICN or sponsor SSAN, two options on the **L**ocate pull-down menu become active, i.e., "**L**ocate Next" or "**L**ocate Previous", allowing the user to go to the next or previous claim set containing that ICN or SSAN.

For example, if a user wants to see all of the sets with claims containing sponsor SSAN "123456789", the user will select the "Sponsor SSAN" and enter "123456789" in the value box on the **L**ocate Value pull-down menu. The system will display the first set containing a claim with a sponsor SSAN of "123456789". After viewing this set, the user can again select the **L**ocate function on the menu bar. If additional sets containing this SSAN exist in the database, the **L**ocate Next option on the pull-down menu is activated. If selected, the system will bring the second set containing sponsor SSAN "123456789" into view. The user may continue to request the next claim set until no more are found in the system.

Likewise, if the **L**ocate Previous button is selected, a previous claim set containing the selection criteria will be displayed. The user may continue to request previous claims sets

until no more are found in the system. The user can move between claims sets by using the **NEXT** and **PREVIOUS** options.

4.1.4. Modify

The **M**odify function enables a contractor to change the **Owner FI** field in a multi-contractor claim set or assign a contract/region to a multi-contractor claim set received from another contractor.

Each contractor will see two options in this function: **Owner FI** *(only if it is a multi-FI set)* and **Owner Region** *(always)*. The **Owner FI** can select the **Owner Region** option to change the **Owner Region** assigned to the set. If the set is a multi-contractor set, the **Owner FI** also can select the **Owner FI** option to change the **Owner FI** to another contractor (Responsible FI). If a set is transferred to a new **Owner FI**, the new **Owner FI** must select the **Owner Region** option to change the **Owner Region** from "Region Unknown" to the applicable region associated with that set.

The **M**odify function also has a **G**overnment option for a select group of TMA staff. This option is not visible to contractor users. The **G**overnment option has a **S**tatus function that allows authorized TMA users to change the status of a set. The status of a set will not be changed by a TMA user without first coordinating the change with the applicable contractor.

4.1.5. Report

The **R**eport function offers a selection of report and graph formats. See *Section 8* and *Addendum E,* for descriptions of the available reports and detailed instructions on using the **R**eport function.

4.1.6. Utility

The **U**tility function enables a user to:

4.1.6.1. View **M**odify FI Explanation - View (but not edit) explanations given for changing the **Owner FI** field in multi-contractor sets.

4.1.6.2. Change or View **V**alidate Explanation - View explanations entered for validate claim sets and edit these explanations.

4.1.6.3. View **R**eason Code Explanation - View (but not edit) explanations associated with certain reason codes. The system requires that certain reason codes be supported by a narrative explanation. Users are prompted for the explanation when certain reason codes are selected.

4.1.6.4. Create, Change, or View **N**otepad - The **N**otepad function provides users with the capability to attach notes or comments to a set. **N**otepad entries are made at the set level. When ownership of a set changes, **N**otepad entries are carried with the set. **N**otepad entries may contain whatever the user wishes. To create or edit a **N**otepad entry, the user should select the **U**tility function. From the drop-down menu, the user should select "Create,

Change, or View Notepad". In the screen that appears, the user can enter or edit text or delete the note altogether.

4.1.6.5. Download - Initiate a download of data to a local PC for ad hoc query and reporting purposes.

4.1.6.6. Modify Set User Defined Codes - Available to and used by a limited number of users selected by each contractor to create, modify, activate, de-activate or delete Set Level User Defined Codes for that region. (See paragraph 3.2.2. for additional information.)

4.1.6.7. Modify Claim User Defined Codes - Available to and used by a limited number of users selected by each contractor to create, modify, active, de-activate or delete Claim Level User Defined Codes for that region. (See paragraph 3.2.6. for additional information.)

4.1.6.8. Unarchive Set - This option is only available when the user is in the History database. It may only be used by a limited number of users selected by each contractor. It allows the user to move the set from the History database to the Active database where changes to the set can be made.

NOTE: Sets that are unarchived will appear in the production database in *Closed* or *Validate* status. On a monthly basis, immediately following the monthly load process, the DCS will sweep the production database for sets that have been in *Closed* status for two years or *Validate* status for five years and will archive, i.e., move, these sets to the history database. If a user unarchives a set and does not change the status from *Closed* or *Validate* to *Open* or *Pending* immediately after unarchiving the set, there is a risk that the set will be returned to the History database.

4.1.7. Help

The Help function also allows the user to select About from the pull-down menu. About informs the user of the version number of the *DCS* operating on that particular PC.

4.2. User Defined Fields

The *DCS* provides contractors with three user defined fields. The purpose of these fields is to provide mechanisms for contractors to meet their own administrative and tracking needs. Two of the three user defined fields allow certain identified users to create, modify, activate, de-activate, or delete contractor defined code values (set level user defined field and claim level user defined field). The third user defined field is the "Solicited Indicator" field (**S?**). This field has three valid values, 'Y', 'N', or blank. The following describes each of these fields and their use.

4.2.1. Set Level User Defined Field

The set level user defined field is located in the upper portion of the DCS screens. This field may contain any two-character alphanumeric value that has been defined by the user. The two-character codes are unique to each region and are deleted should the set be transferred to another contractor. These user defined codes may be used for any purpose needed by the user. Codes may be useful for tracking or reporting purposes. Values may be

entered in this field when user defined codes have been defined for a region and the set is in *Open* or *Pending* status. Only contractor-specified users may define set level user defined field codes.

The contractor-specified users will see the "Modify **S**et User Defined Codes" selection on the **U**tility menu. Users who do not have permission to create, modify, activate, de-activate, or delete user defined codes will not see these selections. To define a code:

- Click on the **U**tility function on the menu and select "Modify **S**et User Defined Codes." A table will appear.
- Click on the **ADD CODE** button. A new record will be added to the table and the cursor will move to the **Contractor FI #** field.
- Click on the down arrow to select the applicable Contractor FI number. Only those numbers for which the user has permissions will be available to select.
- Click on the **Contract #** field to select the corresponding contract number associated with the **Contractor FI #** that was selected in the previous step.
- Click on the **Code** field and enter the two-character code desired.
- Click on the **Code Description** field and enter a description for the code created in the previous step.
- Once the description has been entered, either accept the default of 'Y' in the **Active? (Y/N)** field or change it to 'N' if the code will be activated at a later time.
- Click **OK** and save the changes when prompted. *Click the **RETURN TO SET** button to* return to the CLAIM SET SCREEN.

Once codes have been defined, users can click on the *blue **i** button* and a list of entered codes will appear from which to select. By clicking on a code, it will be entered into the field. Use of this field is not required. Contractors may choose to use it or not use it as they see fit. A number of reports include this field on the Report Parameter Selection Form and in the reports themselves. This field is also included in contractor initiated downloads of set data.

4.2.2. Claim Level User Defined Field

The claim level user defined field is located in the claim level portion of the CLAIM SET SCREEN. This field may contain any two-character alphanumeric value that has been defined by the user. The two-character codes are unique to each region. These user defined codes may be used for any purpose needed by the user. Codes may be useful for tracking or reporting purposes. Values may be entered in this field when user defined codes have been defined for a region and the set is in *Open* or *Pending* status. Only contractor-specified users may define claim level user defined field codes.

The contractor-specified users will see the "Modify **C**laim User Defined Codes" selection on the **U**tility menu. Users who do not have permission to create, modify, activate, de-activate, or delete user defined codes will not see these selections. To define a code:

- Click on the **U**tility function on the menu and select "Modify **C**laim User Defined Codes." A table will appear.
- Click on the **ADD CODE** button. A new record will be added to the table and the cursor will move to the **Contractor FI #** field.
- Click on the down arrow to select the applicable Contractor FI number. Only those numbers for which the user has permissions will be available to select.
- Click on the **Contract #** field to select the corresponding contract number associated with the **Contractor FI #** that was selected in the previous step.
- Click on the **Code** field and enter the two-character code desired.
- Click on the **Code Description** field and enter a description for the code created in the previous step.
- Once the description has been entered, either accept the default of 'Y' in the **Active? (Y/N)** field or change it to 'N' if the code will be activated at a later time.
- Click **OK** and save the changes when prompted. *Click the **RETURN TO SET** button to* return to the CLAIM SET SCREEN.

Once codes have been defined, users can click *on the blue **i** button* on the **User Def:** field on the CLAIM SET SCREEN and a list of entered codes will appear from which to select. By clicking on a code, it will be entered into the field. Use of this field is not required. Contractors may choose to use it or not use it as they see fit. A number of reports include this field on the Report Parameter Selection Form and in the reports themselves. This field is also included in contractor initiated downloads of claim data.

4.2.3. Solicited Indicator Field (S?)

The **Solicited Indicator** field is located in the lower portion of the claim set screen. It is labeled "**S?**" and follows the **Actual Recoup** field. It also appears in the CLAIM DETAIL SCREEN and is labeled "Solicited Indicator." Use of this field is optional but is recommended that contractors use it to help differentiate actual duplicates requiring recoupment from those that require only HCSR adjustments. A 'Y' in this field indicates that a recoupment will be initiated. A 'N' means that no recoupment action is required (e.g., a refund has already been received or a claim has already been cancelled but a HCSR adjustment needs to be submitted since duplicate HCSRs for the claims reside on the HCSR database. A blank indicates undetermined.

4.3. Finding Claims In Multiple Sets

It is important to note that the *DCS* makes a distinction between a claim and an ICN. A claim contains an ICN plus a HCSR suffix plus a time stamp. Since the *DCS* considers claims with the same ICN but with different suffixes as unique claims, an ICN can appear in multiple sets. For instance, if the *DCS* identified three potential duplicates containing the same ICN but with suffixes 'A', 'B', and 'C', three claims will appear since the system recognizes each as a unique claim. Depending on a number of additional factors, these three claims could appear in one, two, three or more claim sets. As a result, users should not assume that there will always be only one claim per ICN. A user who accesses the **L**ocate function to find a particular claim should pay attention to the HCSR suffix, and should continue to view additional sets by using the Locate **N**ext and Locate **P**revious options until all instances of the ICN and HCSR suffix are viewed and the correct claim and set(s) are located for the intended purpose. Always remember that the data being viewed are HCSR records and not claims history records from a contractor's claims processing system.

The system alerts users when a claim appears in multiple sets. When a claim appears in more than one set, the ICN and suffix appears on the CLAIM SET SCREEN in white print. If a claim does not appear in other sets, the ICN and suffix will be in black *or red* print. A user wishing to move to the next set containing the claim with the same ICN and suffix can double click on the ICN. A dialog box will appear with Locate **N**ext and Locate **P**revious options. The user can select either option and the system will display the requested set(s).

5.0. USER ENTRY OF DATA TO RESOLVE CLAIM SETS

The *DCS* facilitates the resolution of duplicate claims by minimizing the amount of data that must be entered by users. It also provides an easy-to-use environment for data entry.

5.1. The entry of data by contractors is limited to eight fields. Five fields are required and three are optional. Seven fields appear in the CLAIM SET SCREEN and one field in the ADJUSTMENT SCREEN, as described below:

5.1.1. On the CLAIM SET SCREEN, the contractor may enter:

- 'Y' or 'N' in the **Dupe?** field [required].
- A reason code selected from lists built into the system, and a supplemental explanation where necessary (see *Addendum B or click on the "i" in the blue circle for an on-line list*) [required].
- An identified recoupment amount for each actual duplicate identified [required].
- An actual recoupment amount when refunds or offsets are collected [required].
- A user defined code at the set level [optional].
- A user defined code at the claim level [optional].

- A 'Y' or 'N' in the **S?** (Solicited Indicator) field [optional].

5.1.2. On the ADJUSTMENT SCREEN, the contractor may enter a 'Y' in the HCSR Adjustment (**HCSR Adjust?**) field for any claim that has an adjustment displayed on the screen. Note that the adjustment allowed amount, which corrects a duplicate condition and resolves a claim set, appears as a negative number in parenthesis. When adjustments are selected in the system, the negative allowed amounts are converted to a positive value when they are added to the total **Adjust Amount** field and used by the rules of resolution to resolve claim sets.

5.2. After entering data on a CLAIM SET SCREEN or ADJUSTMENT SCREEN, a contractor will notice that the **UPDATE CHANGES** button appears. The contractor may click the **UPDATE CHANGES** button to see if a change in status (*Open* to *Pending* or *Pending* to *Open* only) will occur as a result of the newly entered data. Upon clicking the button, the user will be prompted to select one of the following:

- "Yes" to commit to the database the changes just made.
- "No" to rollback all the changes just made.
- "Cancel" to cancel this operation and go back to the screen.

If the user moves off a claim set after entering data (*i.e.,* by clicking one of the **VCR** buttons or by using the **V**iew or **L**ocate functions), but before clicking on the **UPDATE CHANGES** button, the changes will be automatically sent to the database and the set will be updated.

5.3. In invoking the rules of resolution by clicking on the **RESOLVE** or **UPDATE CHANGES** button, the user instructs the system to look at the values in the three total amount fields. The three total amount fields are:

5.3.1. Total Amount Identified for Recoupment (**ID Recoup**), computed from the sum of the amounts the user enters at the claim level on the CLAIM SET SCREEN.

5.3.2. Total Amount Actually Recouped (**Actual Recoup**), computed from the sum of the amounts the user enters at the claim level on the CLAIM SET SCREEN.

5.3.3. Total Allowed HCSR Adjustment Amount (**Adjust Amount**), computed from the sum of HCSR allowed amounts on the adjustments flagged with a 'Y' in the HCSR Adjustment (**HCSR Adjust?**) field on the ADJUSTMENT SCREEN.

The system subjects the totals in these three fields to the rules of resolution and determines if other data elements entered by the user satisfy the rules of resolution for a *Closed* or *Validate* claim set status. See *Section 2, paragraph 5.0.,* for a description of the rules governing the resolution of claim sets in the system, and *Section 4, Figure 9-4-1,* for a flow diagram of these rules.

MULTI-CONTRACTOR CLAIM SETS

On occasion, two different contractors will pay for the same billed services. These types of duplicate payments are a result of jurisdictional processing errors. To ensure that this type of duplicate payment is addressed in the Duplicate Claims System *(DCS)*, special data fields and procedures have been incorporated.

1.0. DESCRIPTION OF A MULTI-CONTRACTOR CLAIM SET

A multi-contractor claim set contains potential duplicate claims processed by two or more contractors. A multi-contractor set, consisting of **Responsible FIs** 06 and 25, is shown in Figure 9-6-1. The resolution of multi-contractor claim sets requires coordination between/among the contractors involved. Multi-contractor sets always involve an erroneous payment because only one contractor is responsible for processing and paying for services within a jurisdiction at any given time. When two different contractors pay for the same billed service, it means that one or more of the claims in the set were erroneously processed and paid by a contractor who did not have processing jurisdiction.

As with all other potential duplicate claim sets, the *DCS* assigns ownership of each set, i.e., responsibility for resolving the set, to the contractor who submitted the claim with the latest processed to completion *(PTC)* date. This contractor becomes the **Owner FI**, who must research the claims in the set to determine if they had jurisdiction for the billed services. If the assigned **Owner FI** determines that they did not have processing jurisdiction for the claims in the set and, therefore, paid the claims in error, the **Owner FI** must resolve the duplicate situation. This means that the **Owner FI** must remain as the **Owner FI**, indicate that a duplicate condition exists in the set, initiate recoupment of the overpayments, ensure receipt of the refunds/offsets, submit appropriate *Health Care Service Record (*HCSR*)* adjustments, verify that these adjustments are reflected in the HCSR database, and resolve the set.

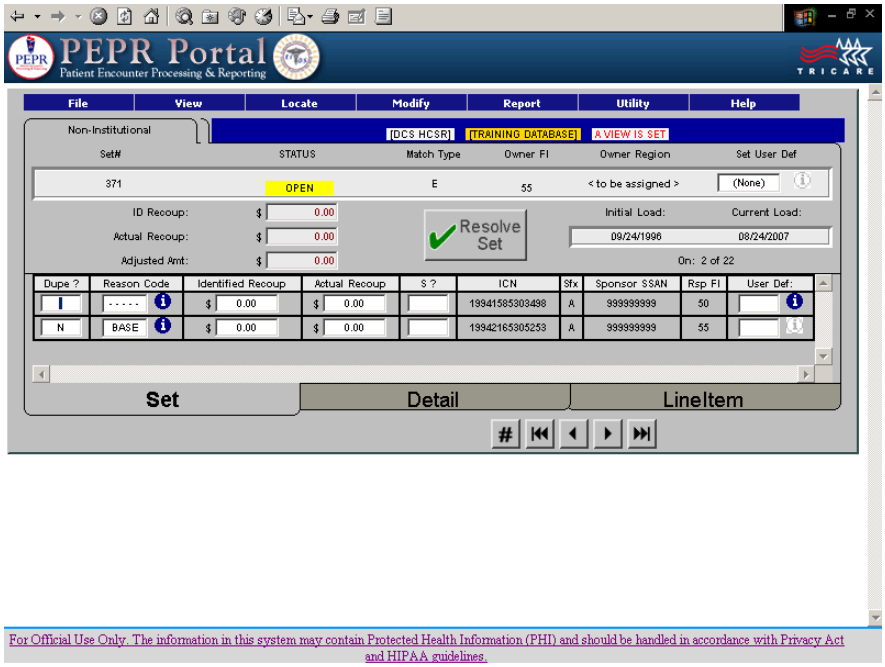
If, however, the **Owner FI** determines that they did have processing jurisdiction for the claims in the set and, therefore, the other contractor paid the claim(s) in the set in error, the current **Owner FI** must change ownership of the set to the other contractor for resolution.

Changing set ownership (i.e., the **Owner FI** field) is a function limited to multi-contractor sets. Ownership of other duplicate claim sets cannot be changed by a contractor. Only multi-contractor sets can be changed. The **Owner FI** change is restricted to the contractors (**Responsible FIs**) that processed claims in the set or are responsible for claims transferred in a contract transition. See *Section 7,* for more details about contract transitions.

When ownership of a multi-contractor claim set is changed, the set is moved from the view of the old **Owner FI** to the new **Owner FI**. The new **Owner FI** becomes the new "owner" of the set and assumes responsibility for resolving the duplicate situation in the set.

The old **Owner FI** uses the **M**odify function on the menu bar to re-assign ownership of the claim set to the other contractor.

FIGURE 9-6-1 SAMPLE MULTI-CONTRACTOR CLAIM SET



The system uses three fields to manage the assignment of responsibility for resolving duplicate claims in multi-contractor claim sets. By default, the system assigns the **Owner FI** field to the contractor that processed the claim with the latest *PTC* date. Multi-contractor claim sets appear along with all other claim sets assigned to the same **Owner FI**. Other contractors will not have access to these sets.

The **Responsible FI** field is used to identify the contractor who is currently responsible for a claim. This field is shown for each claim listed on the CLAIM SET SCREEN and the CLAIM DETAIL SCREEN. The **Processing FI** field is used to identify the contractor that paid the claim. This field is shown on the CLAIM DETAIL SCREEN. These fields are described below.

1.1. Owner FI Field

This field is assigned by the *DCS* to each claim set. The **Owner FI** field designates the contractor responsible for resolving the claim set.

1.2. Responsible FI Field

This field is assigned by the *DCS* to each claim in a set to identify the contractor responsible for correcting any errors in the claim and for recouping any overpayments of actual duplicate payments. The **Responsible FI** of the claim with the latest *PTC* date is also assigned as the **Owner FI** of the set. During a contract transition, the system looks at all

claims belonging to the outgoing contractor and determines if the **Responsible FI** field should be changed to the incoming contractor. If the claim is included in the transition plan, the system will change the **Responsible FI** field to the incoming contractor or to the inactive designation of FI 99. The FI 99 designation will appear on the screen in red. If the claim is not included in the transition plan, the system will leave the field unchanged. See paragraph 5.0., for additional information.

1.3. Processing FI Field

This field is a claim-level data element that is extracted from the HCSR. It contains the FI number of the contractor that originally processed the claim. The **Processing FI** field cannot be changed in the *DCS*.

2.0. SYSTEM FEATURES UNIQUE TO MULTI-CONTRACTOR CLAIM SETS

The layout of the data and the screens available for viewing and entering data in multi-contractor claim sets is the same as the layout of single contractor claim sets. In multi-contractor sets, though, the contractor who is designated the **Owner FI** can change the **Owner FI** field to designate the other contractor as the **Owner FI**. This process is initiated as follows:

2.1. Click on the **M**odify function on the menu bar.

2.2. Click on the **Owner FI** option from the drop-down menu.

2.3. The system displays the FI number(s) of the other contractor(s) in the set. Click on the contractor to be designated as the new **Owner FI**.

2.4. This feature also requires the current **Owner FI** to document contact with the contractor to which the set will be transferred and provide an explanation for why ownership of and responsibility for resolving the set is being changed. When a new **Owner FI** is assigned, the **Owner Region** field changes to "<to be assigned>". The new **Owner FI** subsequently can click on the **M**odify function, **Owner Region** option, and select the appropriate **Owner Region**.

A system feature unique to multi-contractor sets is the rule for changing the status of a set to *Pending*. In effect, the system ignores the claims in the set in which the **Responsible FI** is not the **Owner FI**. It allows an **Owner FI** to move a set to a *Pending* status if there is one BASE claim and all of the **Owner FI**'s claims meet the general conditions for *Pending* status. That is, all **Owner FI** claims must have a dupeflag and reason code, there must be a 'Y' claim, and every 'Y' claim must have an identified recoupment amount greater than $0.00. According to this rule, the status of a multi-contractor set may change as the **Owner FI** changes. For example, if the **Owner FI** identifies all of their claims as actual duplicates and enters a 'Y' in the **Dupe?** fields, selects reason codes and enters amounts identified for recoupment, and leaves the other contractor's claim as the BASE claim, and clicks the **UPDATE CHANGES** button, the status of the set will move to *Pending*. However, if the **Owner FI** changes the **Owner FI** field to the other contractor that has only the BASE claim, the new **Owner FI** will receive the set in *Open* status. According to the rules, the new **Owner FI** does not have actual duplicate claims with associated amounts identified for recoupment.

Since *Pending* status means pending recoupment and since the new **Owner FI**'s claim is the BASE claim and is not one of the duplicates, the set cannot be pending recoupment for the new **Owner FI**. The set would be in *Pending* status for the old **Owner FI** not the new **Owner FI**.

2.5. Another system feature unique to multi-contractor claim sets is the special logic invoked for multi-contractor appended sets. When a new claim is identified during the monthly extract as a potential duplicate of a claim in an existing set, the set is called an appended set. In appending a new claim to a set, the system applies the general rule of assigning the **Owner FI** to the **Responsible FI** of the claim with the latest *PTC* date if the status of the set is *Open* or *Closed*. If the status of the set is *Pending* or *Validate*, the system ignores this rule and leaves the current assignment of the **Owner FI**. The system also applies special logic to determine the status of multi-contractor appended sets. The status of multi-contractor sets with an appended claim is determined as follows:

- *Open* sets will remain *Open* because recoupment had not been initiated on the set prior to the new claim being appended.

- *Pending* sets will remain *Pending* to allow the **Owner FI** to complete recoupment of actual duplicate payments prior to determining if additional research is required or if the set should be transferred to another contractor.

- *Validate* sets will be changed to *Pending* to allow the **Owner FI** to determine if the appended claim changes the Validate situation prior to determining if additional research is required or if the set should be transferred to another contractor.

- *Closed* sets will be changed to *Open* to allow the **Owner FI** to determine if the appended claim requires additional research or if the set should immediately be transferred to another contractor.

3.0. COORDINATION REQUIREMENTS WHEN WORKING WITH MULTI-CONTRACTOR SETS

Resolution of multi-contractor claim sets requires close coordination between the contractors involved to ensure that research efforts and resolution activities are conducted efficiently, appropriately, and in a timely manner. When researching a multi-contractor set, the **Owner FI** must coordinate with the other contractor(s) involved to determine who is responsible for the duplicate payment(s) and for recouping the overpayment(s). The method of coordination must be negotiated between contractors and may take whatever form is agreeable, i.e., by telephone, fax, e-mail, or combination thereof. This coordination is a courtesy among contractors and should prevent indiscriminate transfers of sets back and forth. If the current **Owner FI** is not responsible for the duplicate payment, the current **Owner FI** should contact the other contractor to advise them of the set, its upcoming transfer, and to discuss or describe the circumstances involved. Ownership of the set must not be changed to another contractor until the receiving contractor has been consulted and an explanation has been entered into the system justifying the switch.

The explanation entered into the system must contain:

- The date the other contractor was contacted.
- The name and telephone number of the person making the contact from the current **Owner FI**.
- The name and telephone number of the person contacted at the contractor to which ownership of the set is being changed.
- A brief explanation for the change of ownership (e.g., "This claim falls within the jurisdiction of Region 13. Contractor for Region 14 paid claim in error and is responsible for recoupment of the overpayment.").

4.0. RESOLVING MULTI-CONTRACTOR CLAIM SETS

Multi-contractor claim sets are resolved in the same manner as all other claim sets in the *DCS*.

4.1. When the initial **Owner FI** conducts research and determines that they were responsible for the duplicate payment, the contractor can initiate recoupment and resolve the claim set in accordance with the rules of resolution.

4.2. When the initial **Owner FI** determines that the duplicate payment belongs to a different contractor, the current **Owner FI** must contact the other (receiving) contractor and discuss or describe the situation before the current **Owner FI** can change ownership. The current **Owner FI** must document the contact and the reason for the change in set ownership. Although the current **Owner FI** may enter a 'Y' in the **Dupe?** field of the other contractor's claim, it is recommended that this action be reserved for the **Responsible FI** of the claim. The **Owner FI** transferring the set may not enter an amount identified for recoupment for the other contractor's claims.

4.3. After documenting the contact and agreement to change set ownership, the current **Owner FI** may change ownership to the other (receiving) contractor. Once ownership is changed in the system, the receiving contractor (the new **Owner FI**) can view the set, initiate recoupment action, and resolve the claim set in accordance with the rules of resolution. Multi-contractor sets must not be resolved without communication and coordination among the involved contractors. *The only exceptions to this are multi-contractor sets in which the only other contractor involved is FI 99.*

4.4. If a multi-contractor set contains a BASE claim and two or more additional claims processed by different contractors, ownership must be transferred to each contractor responsible for the non-BASE claims in order to resolve the set. Each contractor is responsible for identifying their duplicate payments, initiating recoupments, and submitting HCSR adjustments corresponding to their refunds and offsets. The set cannot be resolved unless all resolution requirements have been met.

4.5. Ownership of multi-contractor sets may switch back and forth between contractors as research is conducted and determinations about jurisdictional responsibility are made.

When a set changes ownership, only the current **Owner FI** can view the set, including all adjustments. The current **Owner FI** is never permitted to enter recoupment amounts in the other contractor's claim. The current **Owner FI** is, however, permitted to flag an adjustment submitted by another contractor to facilitate resolution.

5.0. RESOLVING CLAIM SETS CONTAINING INACTIVE FI 99 CLAIMS

Section 7, describes how the transition plan will determine if an outgoing contractor's claim should be transferred to the incoming contractor or to an inactive status of FI 99. If a claim in a multi-contractor set is transferred to FI 99, special logic is applied to the resolution of the set. The system will not permit a multi-contractor set to have an **Owner FI** of 99. Therefore, if the **Responsible FI** on the claim with the latest *PTC* date is FI 99, the **Owner FI** will be assigned to another **Responsible FI**.

The resolution of multi-contractor sets normally requires **Owner FI**s to identify at least one actual duplicate claim in the set. However, special logic is applied to multi-contractor sets containing an inactive FI 99 claim. If there are no other active contractors in the set, the **Owner FI** can resolve the set without identifying an actual duplicate claim. In other words, if the **Owner FI** is the **Responsible FI** of one claim in the set and the other claim has a **Responsible FI** of 99, the **Owner FI** can identify both claims as non-duplicates and resolve the set to a *Closed* status. The **Owner FI** also can resolve sets containing FI 99s according to the general rules of resolution in which actual duplicates are identified, recoupments are received, and adjustments are processed.

Sets with FI 99 claims are simply another type of multi-contractor set. When confronted with an FI 99 set, the **Owner FI** needs to determine if it had jurisdiction for the claim(s) it paid. For FI 99 sets the **Owner FI** should enter an 'N' in the **Dupe?** fields and enter either "BASE" or "N300" in the **Reason Code** fields of the FI 99 claims. For the **Owner FI**'s claims, an 'N' or a 'Y' may be entered in the **Dupe?** field and a valid reason code should be entered.

NOTE: An **Owner FI** claim may be designated as the BASE claim. If the **Owner FI** determines that it did not have jurisdiction for the claim(s) it paid, then it must put a 'Y' in the **Dupe?** field(s) of its claim(s).

6.0. DETERMINING JURISDICTION FOR CLAIM SETS INVOLVING "SNOWBIRD" CLAIMS

6.1. "Snowbird" claims are claims involving TRICARE Standard beneficiaries who move seasonally from one area of the country to another and tend to have two addresses. For example, a TRICARE Standard beneficiary may reside in New York for the summer months and move to Arizona during the winter. Frequently, when such beneficiaries receive health care, they will give the provider both their local address and their other residence address in the other TRICARE region. The provider may then submit a claim to the TRICARE regional contractor that covers the region in which the beneficiary currently resides showing the beneficiary's local address on the claim. The provider may then send a second claim to the TRICARE regional contractor that covers the region in which the beneficiary resides during the other part of the year showing the beneficiary's other residence address on the claim. When each contractor receives the claim, they see that the address on the claim is within their

region and they proceed to process and pay the claim. Each contractor does not know that the other has paid the same claim. When this happens, the *DCS* identifies the duplicate payments and creates a multi-contractor set. The issue in resolving these sets is determining which contractor had jurisdiction for the claim and which made the overpayment that needs to be recovered.

6.2. Since TRICARE Standard beneficiaries are by definition not enrolled, there are no enrollment records upon which regional jurisdiction can be determined. Instead, regional jurisdiction for TRICARE Standard claims processing purposes is generally based on the residence address appearing on the claim, the address residing on *Defense Enrollment Eligibility Reporting System (*DEERS*)*, and on any address information residing in the Contractor's files. Beneficiaries may not have updated DEERS with what they consider to be their primary residence address. When this happens there will be discrepancies between the addresses on the claims and the address appearing on DEERS. If a beneficiary has not had any previous claims processed, there will not be any claims history available to the contractor for research. Sometimes it is not possible from existing claims or other information to determine a beneficiary's primary residence and therefore determine which contractor has jurisdiction for the claim.

6.3. As with all multi-contractor *DCS* sets, the contractors involved must communicate and coordinate with each other in order to resolve "snowbird" multi-contractor sets. The following steps shall be taken by the contractors to resolve this type of multi-contractor set.

6.3.1. The **Owner FI** of the multi-contractor set shall contact the other contractor(s) involved and advise them of the existence of the set (remember, only the **Owner FI** can see the set). In consultation with each other, if the primary address can be determined from existing information residing with the involved contractors and a decision can be made as to who has jurisdiction for the claim, then the set may be handled as any other multi-contractor set. Existing information may include previous claims history, customer service contacts (by phone, walk-in, or correspondence), DEERS address data, etc. Note that if both contractors have existing claims history and there is no other corroborating information as to the correct primary residence address, then the **Owner FI** must develop for the correct address to determine jurisdiction (see *paragraph 6.3.2.*).

6.3.2. If the primary address cannot be determined from existing information residing with the involved contractors, then the **Owner FI** shall develop for the primary residence address. Development for the primary address shall include: telephone calls to the patient, telephone calls to the provider, sending letters to the patient at both addresses requesting that the patient designate a primary address and requesting that they update DEERS with their primary residence address.

6.3.3. If none of the development efforts succeed and the primary residence address cannot be determined, the **Owner FI** shall contact the other contractor(s) involved and the contractor that processed the claim with the latest *PTC* date shall be the contractor deemed to have made the overpayment and therefore responsible for initiating recoupment. If that contractor is not the current **Owner FI** of the set, then the set shall be transferred to that contractor. In the rare event that the claims were processed on exactly the same date and at exactly the same time, the contractors, in consultation with each other, may decide which shall initiate recoupment. The actions taken and the decisions made by the contractors shall

be documented in the system either in the DCS Notepad or in the dialog box that prompts users for an explanation when transferring sets to another contractor. At a minimum, the documentation shall include the names of the people involved in the discussions from each of the contractors, the date(s), and the decisions made.

MASS CHANGE FUNCTION FOR CONTRACT TRANSITIONS

1.0. CONTRACT TRANSITIONS

When a new contract is awarded, the Government establishes a transition plan for the outgoing and incoming contractors. This plan specifies the schedule for implementing transition activities, e.g., dates when certain types of claims and encounters become the responsibility of the new contractor.

A contractor has access to and can view only those potential duplicate claim sets for which the contractor has responsibility for resolving and is the designated **Owner FI**. When a contract transition occurs, access to the duplicate claim sets must be transferred to the incoming contractor for resolution, in accordance with the transition plan. The date the incoming contractor will assume responsibility for resolving the claim sets owned by the outgoing contractor will be determined during transition meetings. The type of claim sets (e.g., financially underwritten or non-financially underwritten), that will be transferred to the incoming contractor will be determined at transition meetings. The **Responsible FI** field may be changed to an inactive FI 99 for claims that will remain the responsibility of the outgoing contractor.

For example, claim sets involving financially underwritten claims may remain the responsibility of the outgoing contractor, while non-financially underwritten claim sets may become the responsibility of the incoming contractor at some specified time during the transition period. Under the terms of the transition plan, the incoming contractor will be responsible for resolving the claim sets transferred to them from the outgoing contractor, including all recoupments and submissions of adjustment and cancellation *Health Care Service Records (*HCSRs*)*.

2.0. NEED FOR THE MASS CHANGE FUNCTION

When HCSRs representing potential duplicate payments (along with their corresponding adjustment and cancellation HCSRs) are extracted from the HCSR database and loaded into the Duplicate Claims *d*atabase, ownership (i.e., the **Owner FI** field) of each claim set is assigned. Additionally, a **Responsible FI** is assigned for each claim in the set. (See *Section 6, paragraph 1.2.,* for the definition of this field.) The contractor that is the **Owner FI** is responsible for resolving the set. When a contract transition occurs, responsibility for resolving a set may change. The Mass Change function manages this process by changing the **Responsible FI** field of all claims included in the transition plan. This field may be changed to the incoming contractor or to an inactive FI 99. It also may be left unchanged if the outgoing contractor remains an active contractor. The Mass Change function also changes the **Owner FI** field as appropriate.

For example, Contractor 1 has been using the Duplicate Claims System *(DCS)* for a year and the *DCS* has been extracting potential duplicates, creating claim sets and assigning ownership of these sets to this contractor. Effective, February 1, 2003, three states are carved out of this contractor's region and a new region is established. Contractor 2 is awarded the contract for this new region. The transition plan establishes that Contractor 2 will assume full responsibility for resolving no*n*-financially underwritten potential duplicate claim sets, previously the responsibility of Contractor 1, for these three states, on June 1, 2003. The *DCS* will identify the affected non-financially underwritten claims and change the **Responsible FI** field of the affected claims and the **Owner FI** field of the affected sets to Contractor 2 effective June 1, 2003.

3.0. DEFINING MASS CHANGES

The *TRICARE Management Activity (*TMA*)* is responsible for initiating the Mass Change function upon determination of the transition plan requirements pertaining to duplicate claims resolution. Mass Changes are initiated by the submission of Mass Change Specification Forms to the TMA *Automated Data Processing (*ADP*)* Facilities Management Services Contractor who is responsible for making the changes in the Duplicate Claims *d*atabase. A sample form is shown in Figure 9-7-1.

The Mass Change Specification Form lists the data fields in the Duplicate Claims *d*atabase that may be used to identify claims and claim sets whose "ownership" must be changed to accommodate a contract transition. Once a Mass Change is performed, affected claims and claim sets will be accessible to the incoming contractor and removed from the view of the outgoing contractor.

FIGURE 9-7-1 MASS CHANGE SPECIFICATION FORM

MASS CHANGE LEVEL: _____ MASS CHANGE SEQ: _____

DATA FIELD	FIELD LENGTH	VALUE
Mass Change Effective Date (DD MON YYYY format: 01 JUL 1995)	dd mmm yyyy	
Claim Set Status (Circle all affected by this change)	1	O, P, C, V, H
Claim Responsible FI (current value before Mass Change)	2	
Claim Responsible Contract (current value before Mass Change)	7	
Claim Processing FI	2	
Claim Processing Contract	7	
Beneficiary Region	2	
Provider Region	2	
Special Processing Codes	2	
Special Rate Code	2	
Financially Underwritten Indicator	1	
Provider Affiliation Code	1	
Filing State Code	2	
Beneficiary Zip Code Range	9	FROM: TO:
Provider Zip Code Range	9	FROM: TO:
Beneficiary Catchment Area Indicator	1	
Provider Catchment Area Indicator	1	
Processed To Completion Date Range	dd mmm yyyy	FROM: TO:
Care Begin Date Range	dd mmm yyyy	FROM: TO:
Care End Date Range	dd mmm yyyy	FROM: TO:
New Responsible FI	2	
New Responsible Contract	7	

Submitted by:_____ Date:_____
Approved by:_____ Date:_____

4.0. PERFORMING MASS CHANGES

The steps for performing a Mass Change are as follows:

4.1. The types of claims and claim sets to be transferred to a new contractor as well as the effective dates are defined in the transition plan.

4.2. These requirements are entered on the Mass Change Specification Form by TMA.

4.3. The Mass Change Specification Form is submitted to the TMA ADP Facilities Management Services Contractor at least two weeks prior to the date the change is to be effective.

4.4. The TMA ADP Facilities Management Services Contractor incorporates the mass change conditions after completion of the monthly load immediately preceding the mass change effective date.

4.5. The TMA ADP Facilities Management Services Contractor creates a report of the claims affected by the change.

4.6. TMA reviews and approves the list of claims.

4.7. Unless otherwise directed, the mass changes are thereafter applied to affected claims.

5.0. ADMINISTRATION OF MASS CHANGES

Mass changes will be strictly controlled by TMA in accordance with each contract's transition plan. See *Addendum D,* for a description of the activities and time tables that can be incorporated in a contractor to contractor transition plan.

The Mass Change function ensures that claims affected by a transition are identified and appropriately assigned. This means that the **Responsible FI** field will be changed for all claims included in the transition plan. For example, a transition plan may require that on June 1, 2003, all non-financially underwritten claims will be transferred from the outgoing Contractor FI 75 to the incoming Contractor FI 89. At the same time, all financially underwritten claims belonging to FI 75 will be changed to an inactive designation of FI 99.

5.1. Changes To The Owner FI

The Mass Change function also determines if the **Owner FI** should be changed. The system uses the following logic to determine the **Owner FI**.

5.1.1. If the **Responsible FI** being changed is not the owner of the set, then the **Owner FI** will not change.

5.1.2. If the **Responsible FI** being changed is the owner of the set and the **Responsible FI** is being changed to an FI other than 99, and there are no other claims in the set with the same **Responsible FI** as the one being changed, then the **Owner FI** will be changed to the new **Responsible FI**.

5.1.3. If the **Responsible FI** being changed is the owner of the set and the **Responsible FI** is being changed to an FI other than 99, and there is another claim in the set with the same **Responsible FI** as the one being changed, and the claim with the **Responsible FI** being changed has an Identified Recoup amount greater than $0.00, then the **Owner FI** will be changed to the new **Responsible FI**.

5.1.4. If the **Responsible FI** being changed is the owner of the set and the **Responsible FI** is being changed to an FI other than 99, and there is another claim in the set with the same **Responsible FI** as the one being changed, and the claim with the **Responsible FI** being changed has an Identified Recoup amount equal to $0.00, then the **Owner FI** will not be changed.

5.1.5. If the **Responsible FI** being changed is the owner of the set and the **Responsible FI** is being changed to 99, and there are no other claims in the set with an FI other than 99, then the **Owner FI** will be changed to 99.

5.1.6. If the **Responsible FI** being changed is the owner of the set and the **Responsible FI** is being changed to 99, and there are other claims in the set with the same **Responsible FI** as the one being changed, then the **Owner FI** will not be changed.

5.1.7. If the **Responsible FI** being changed is the owner of the set and the **Responsible FI** is being changed to 99, and there are other claims in the set with an FI other than 99, and there are no other claims in the set with the same **Responsible FI** as the one being changed, and there are no non-FI 99 claims with an Identified Recoup Amount greater than $0.00, then the **Owner FI** will be changed to the non-FI 99 claim with the latest processed-to-completion date.

5.1.8. If the **Responsible FI** being changed is the owner of the set and the **Responsible FI** is being changed to 99, and there are other claims in the set with an FI other than 99, and there are no other claims in the set with the same **Responsible FI** as the one being changed, and there are non-FI 99 claims with an Identified Recoup Amount greater than $0.00, then the **Owner FI** will be changed to the non-FI 99 claim with an Identified Recoup Amount greater than $0.00 that has the latest processed-to-completion date.

6.0. RESOLUTION ISSUE INVOLVING TRANSITIONED SETS FOLLOWING A MASS CHANGE

During a transition, when the outgoing contractor has ceased entering refund and adjustment data on the *DCS*, refunds may be received and/or HCSR adjustments may still be submitted for claims in *Open* and *Pending* sets. In this case, the incoming contractor may be required to resolve the set without knowing the amount of the refund received by the outgoing contractor.

If the actual recoupment amount was zero when the set was transferred from the outgoing contractor, the incoming contractor may apply the adjustment to the set while leaving the actual recoupment amount as zero dollars. Resolution would result in a *Validate* status, requiring an explanation by the incoming contractor that the outgoing contractor did not enter the actual recoupment amount.

REPORTS

The Duplicate Claims System *(DCS)* includes an integrated reporting system that generates standard and custom reports. These reports facilitate resolution activities and support contractor and *the TRICARE Management Activity (*TMA*)* auditing and management functions. In addition to the range of user-defined reports and graphs provided by the **R**eport function on the menu bar, the system provides the capability to download data to local tables. This capability, which is accessed through the **U**tility function on the menu bar, enables users to load *DCS* data into other database management or reporting software and subsequently generate a variety of ad hoc queries and reports. See *Addendum E*, for report descriptions and sample reports.

There are 41 predefined and semi ad hoc reports and *two* graphs available to DCS users. Each report/graph has one or two parameter screens which allow the user to refine the report by choosing specific criteria to report on. The following is a list of "standard" parameters/ criteria available for each report.

The "standard" parameters (available on most reports) are:

Claim Set Status	(All, C, O, P, V)
Adjustments	(All, Non-adjusted Sets, Adjusted Sets)
Set Owner Type	(All, Multi FI, Single FI)
Claim Type	(All, Institutional, Non-institutional)
Match Type	(All, C, D, E, N, O)
Date Type	(Initial Load Date, Current Load Date, Last (Update) Date)
Set Range	(beginning and ending set numbers)
FI	(Select one from the list of available)
Region	(If FI selected, select one or more of available)
Exclude Base Claims	*(Check to exclude, leave blank to include)*
Solicited	*(Yes, No, Blank)*
Dupe Flag	*(Yes, No, Blank)*
Set User Codes	*(Select one or many by pressing CTRL and clicking)*
Claim User Codes	*(Select one or many by pressing CTRL and clicking)*

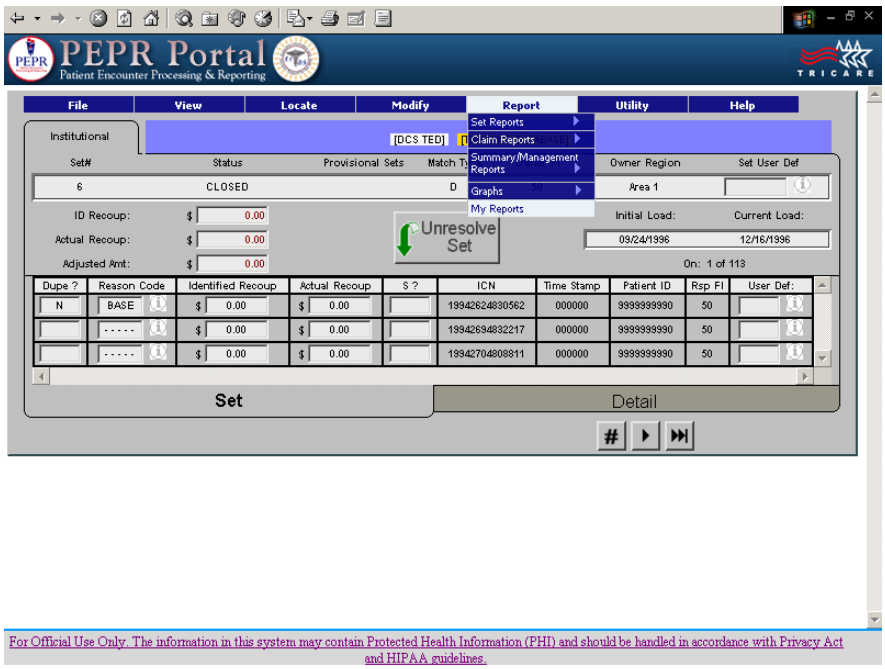
Some reports have other "special" parameters/criteria that may be selected depending on the report. (See *Addendum E*, for report descriptions and available parameters.)

When a user selects a report, a Report Parameter Screen will appear. Every Report Parameter Screen will contain a **Most Common** tab on which the available "standard" parameters applicable for the selected report will be displayed. If the report has associated "special"

parameters available, a second **Special** tab will be visible. Users may further refine their report criteria from the additional parameters on the **Special** tab.

1.0. USING THE REPORT FUNCTION

FIGURE 9-8-1 REPORT CATEGORIES MENU



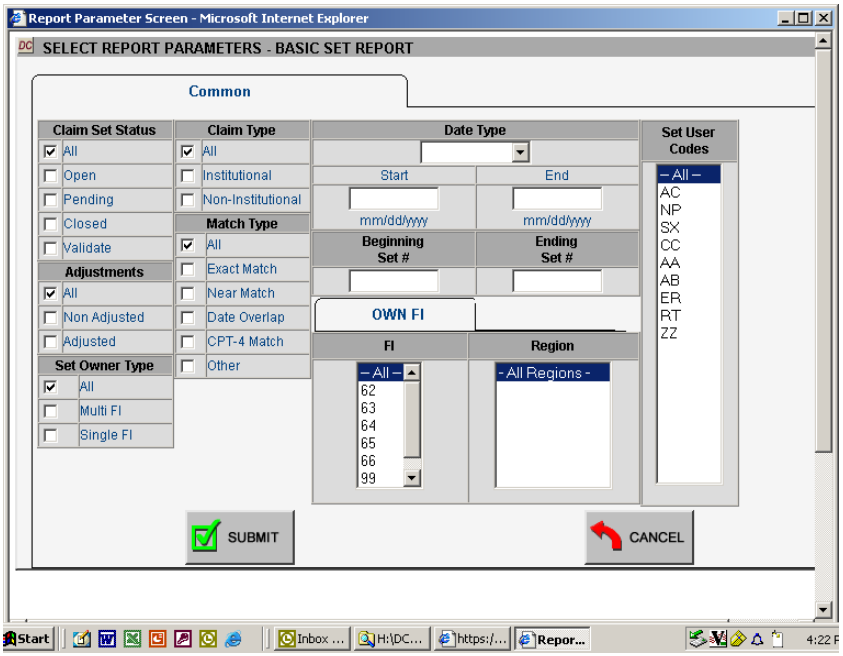
The menu bar on the top of every screen in the *DCS* includes a **R**eport function with a pull-down menu. When a user selects **R**eport from the menu bar, a report categories menu appears (Figure 9-8-1), to display the four selections available to the user:

- Set Reports
- Claim Reports
- Summary/Management Reports
- Graphs
- *My Reports*

When a user selects one of the report categories, a list of the available report formats for that category appears. When a report format is selected, a parameter screen appears and presents the user with available options for limiting the sets and claims to be included in the report. The report parameter screen resembles the **V**iew screen. A number of options are presented from which the user can define the data to be included in the report. Figure 9-8-2, shows an example of options available for selecting data to be included in a report.

Note that the system recognizes if the user is a TMA or contractor user and will display the appropriate options. For example, a contractor is able to print only their own data (i.e., sets assigned to this contractor or region) and not data of other contractors. TMA users are able to generate reports containing data from all contractors.

FIGURE 9-8-2 REPORT PARAMETER SCREEN



The report parameter screen presents available options for data selection criteria based on the user type and the type of report format selected. For example, some report formats permit users to include institutional data, non-institutional data, or both in a report. Other formats are exclusively dedicated to either institutional or non-institutional data. Some report formats permit users to include data based on a range of dates while others do not.

The parameter screen detects the user type and the report format selected and displays only those data selection criteria options available for the user and the selected format.

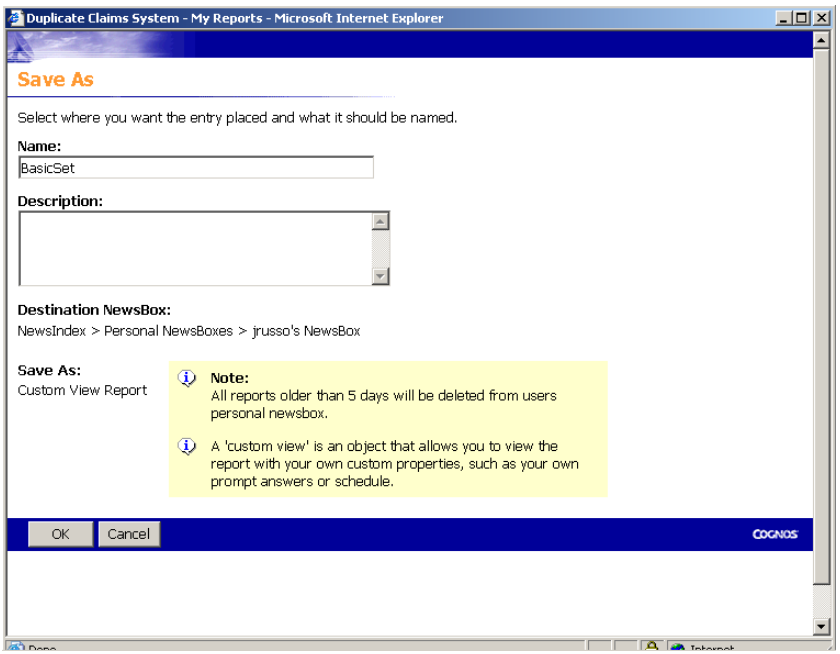
The date range options on the report parameter screen allow a user to specify a selection of sets or claims based on a range of different dates such as:

- Processed-to-Completion *(PTC)* Date - the date when the claim was *PTC*.
- Initial Load Date - the date when the set was initially loaded into the *DCS.*
- Current Load Date - the date when the set was loaded into the Duplicate Claims *d*atabase or when a claim was appended to the set or when set ownership was changed as a result of a mass change or a change in the **Owner FI** field.
- Last Update Date - the date when the set was last updated by a user or by the system.

After a user selects a report format and data parameters and *selecting the **SUBMIT** button. The system displays the **SAVE AS** screen (Figure 9-8-3). At this time the user can enter a*

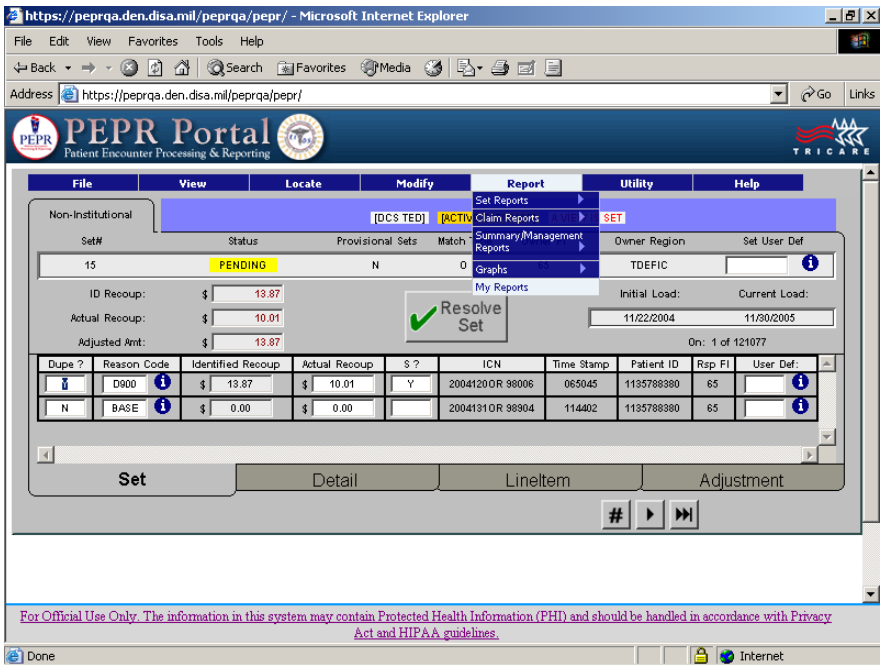
*name for the report and may also add a description. This screen allows the user to continue and produce the requested report by selecting the **OK** button or cancel the request and return to the set by selecting the **CANCEL** button.*

FIGURE 9-8-3 SAVE AS SCREEN



*If the user selects the **OK** button, the system brings the user to the MY REPORTS screen (Figure 9-8-4) that lists all the reports that have been run or requested. The reports that have not been reviewed, will display the caption "New." After five days, the reports on this menu will be deleted automatically. To review and/or print a report, select the report name.*

FIGURE 9-8-4 MY REPORTS SCREEN



*An optional way of getting previously submitted or completed reports is to select the **Reports** function and then select the **MY REPORTS** option from the pull-down menu (Figure 9-8-4). The following screen (Figure 9-8-5) will be displayed.*

FIGURE 9-8-5 REPORTING LISTING

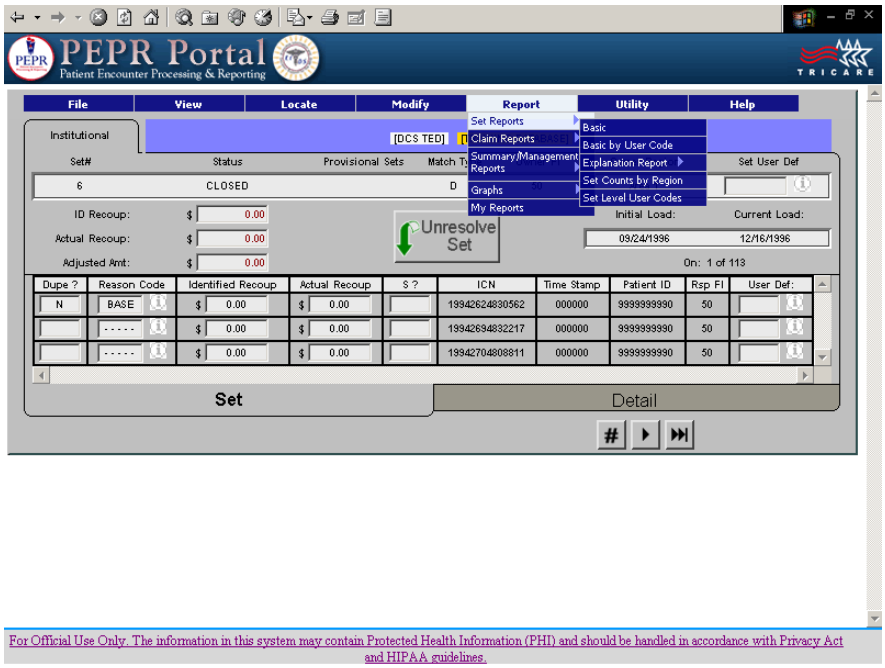
2.0. DESCRIPTION OF REPORTS

Addendum E contains a description and a sample of all available reports. The system groups reports into four categories, which are described briefly below. The first two categories of reports are based on set characteristics and claim characteristics. The other two categories of reports provide a range of summary and management analyses as well as graphical presentations of data. Each of the four categories of reports are further defined by menus to specify report formats and screens on which report parameters can be specified.

2.1. Set Reports

Set reports contain set information based on selection criteria established by the user. In other words, if a set has met the selection criteria for a report, all claims in the set will be included. Set reports are defined through menu(s) of set report formats and report parameter screens. A sample of set report menus are shown in *Figure 9-8-6*.

FIGURE 9-8-6 SET REPORT MENU



2.2. Claim Reports

As the name suggests, claim reports contain listings of individual claims that meet specific criteria based on the report format selected and the filters applied by the user on the report parameter screen(s). Sample claim report menus are shown in *Figure 9-8-7*. Examples of claim reports are:

2.2.1. All institutional claims in sets assigned to a particular region grouped by set status.

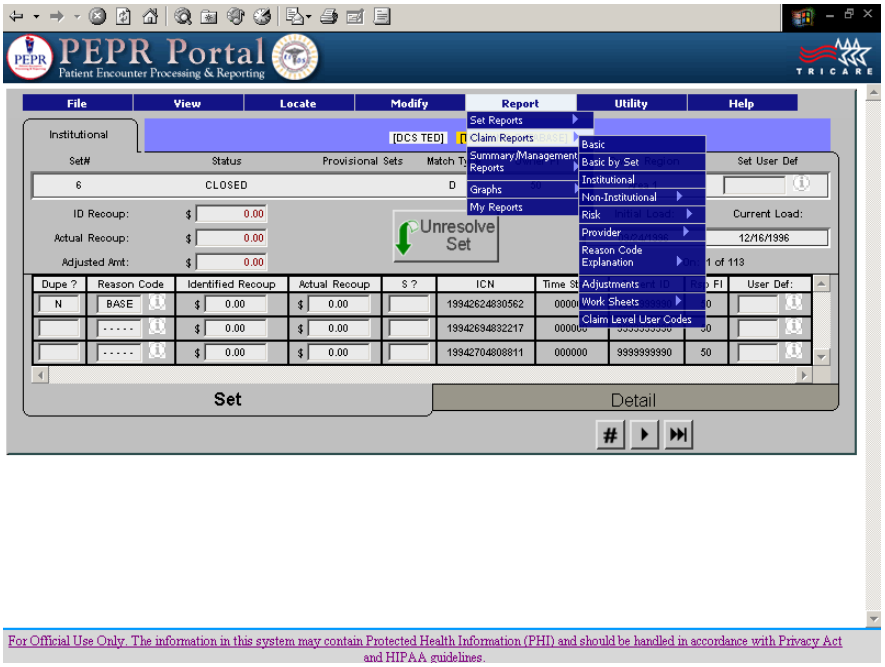
2.2.2. All claims in multi-contractor sets for a particular region by set status and within a specified initial load date time frame.

2.2.3. All claims identified as an actual duplicate in a set with Pending status and with a last update date between a specified date range.

2.2.4. All non-duplicates for a specified region which are not BASE claims.

2.2.5. Special report formats for Claim Reports have been developed for use by a contractor during the various stages of the claim set life cycle. For example, there is a report format that lists the claims identified as actual duplicates for which recoupment should be initiated. This report could be generated by a person researching potential duplicates and sent to the recoupment unit daily. Another report format lists those claims for which recoupments have been received. This report could be generated by a contractor finance unit and sent to the adjustment unit when adjustments/cancellation HCSRs need to be submitted.

FIGURE 9-8-7 CLAIM REPORT MENU

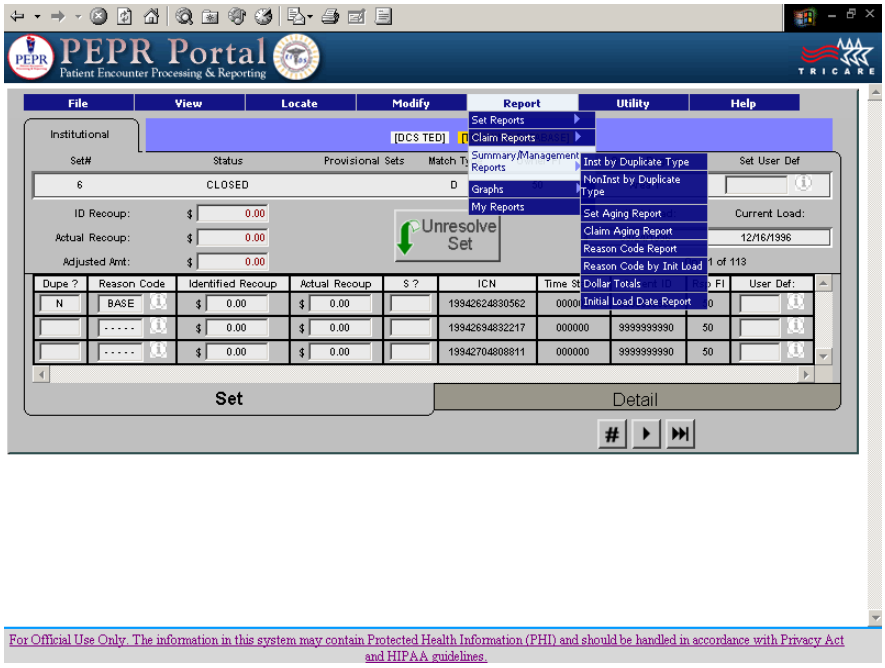


2.3. Summary/Management Reports

Summary/Management Reports display claims and other system data in formats which facilitate analyses and management functions. Sample summary/management report menus are shown in *Figure 9-8-8*. Examples of Summary/Management reports are:

- Set aging reports.
- Claim aging reports.
- Performance reports.

FIGURE 9-8-8 SUMMARY/MANAGEMENT REPORT MENU



2.4. Graphs

The Graphs category of reports displays data in graphical presentations that are useful in management analysis. For example, there is a graph that displays data regarding user activity. Another provides a graphical representation of actual versus potential duplicates. *Sample of the Graphs menu are shown in Figure 9-8-9.*

FIGURE 9-8-9 GRAPHS MENU

The categories of report formats, in concert with report parameter screen options, provide users with flexible reporting tools to generate a wide range of reports. If a desired report cannot be devised through the use of the available report formats and the parameter screen options, users have the ability to download their data to their local hard drives, perform their own queries, and generate customized reports using their own database management spreadsheet, or report generation software.

See *Addendum E* for available report formats.

3.0. USING THE UTILITY FUNCTION TO DOWNLOAD DATA FOR ADDITIONAL ANALYSIS

Users have the capability to download duplicate claims data to their local system for additional analyses and reporting. This feature permits downloading of a contractor's data to a local PC, where it can be accessed from a PC-based database management program (e.g., Paradox®, Access®, dBase®, etc.) or a spreadsheet program or query/report generator. This feature permits the user to perform analyses and develop reports not available in the *DCS*. Depending on the volume of data associated with a particular contractor, the process of downloading data could take some time.

3.1. How To Download Data

To initiate a download, a user should first select **U**tility from the menu bar at the top of the screen*, select **DOWNLOAD** and then select **NEW REQUEST** to start a new download or MY DOWNLOADS to see the status of past download requests*. *If the user selects **NEW REQUEST** then a* pop-up menu appears explaining that the user can download the current "**V**iew" to local ASCII fixed length tables and save them to a directory of the user's choice by clicking the ***OK** button*. A ***CANCEL** button* is also provided to cancel or change the request. If the user clicks "Yes", a matrix is displayed showing the names and brief descriptions of tables that can be downloaded. The user should follow the directions provided and click on the table(s) to be downloaded. A checkmark (✔) will appear to indicate the table(s) that have been selected. The user also can change the default directory to specify another directory to which the download should be saved. Tables available for downloading are:

dcset	set level data
dcclm	claim level data
dcutlztn	line item data
dcutladj	adjustment data
dcsetcmt	set level comments
dccmnt	claim level comments
dcsetlog	set log
dcsetusr	set level user defined codes
dcclmusr	claim level user defined codes
dccount	set counts
dccontract	region table
dcfi	FI/Contractor table
dcreas	reason codes
dcenroll	*enrollment codes*

While the download is being processed, the system will display the message: "**Accessing Database....Working....Please Wait**." This process can take several minutes or hours, depending on the number of claims/sets to be downloaded. The download will create ASCII *fixed-length* text files (files with extension of "txt").

The downloaded ASCII fixed-length files to generate reports, tables have to be defined in the database management software selected (dBase®, Access®, etc.) and the ASCII files imported. *Addendum F*, contains all of the information necessary to create the files, including the key or index fields.

It should be noted that downloaded files cannot be uploaded to TMA systems. This is a security feature to prevent corruption of the Duplicate Claims database.

*From the **Utility** menu, the **Download** pull-down menu allows the user to request a new download or preview previously requested downloads (Figure 9-8-10).*

FIGURE 9-8-10 DOWNLOAD MENU

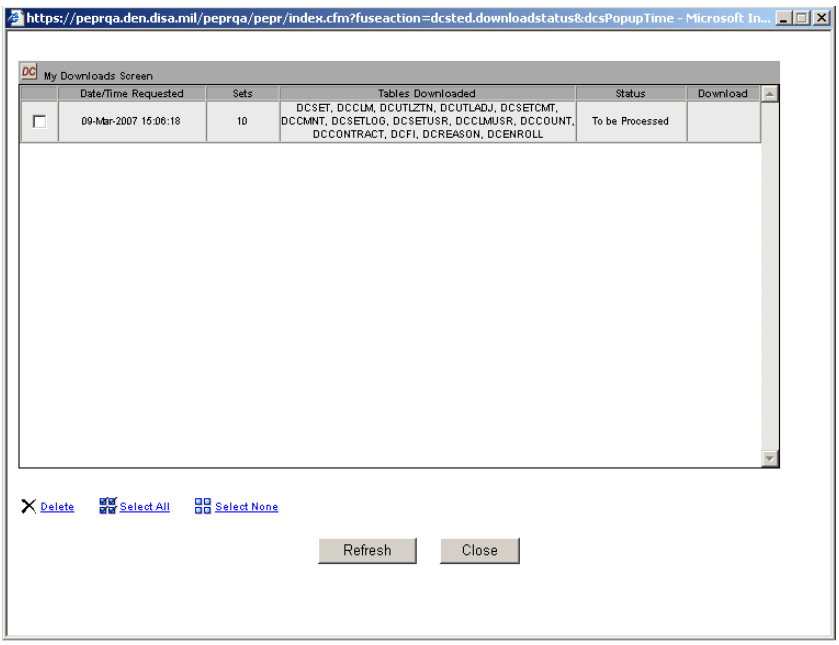
3.2. Specifying Data To Be Downloaded

Data to be downloaded may be specified in two ways. First, users should set a view through the **V**iew function of the menu bar to select specific claim types, set statuses, FIs/regions, match criteria, load dates, PTC dates, owner types, etc. Then, through the **D**ownload feature of the **U**tility function users may specify the data tables to include in the download.

FIGURE 9-8-11 NEW REQUEST PROMPT

*To view download requests, select the MY DOWNLOAD from the **U**tility function. A screen showing the current pending and completed downloads will be displayed (Figure 9-8-12).*

FIGURE 9-8-12 MY DOWNLOADS



SYSTEM IMPLEMENTATION AND OPERATIONAL REQUIREMENTS

This section describes implementation requirements for the Duplicate Claims System *(DCS)*. It also defines policies and procedures for the operation of the system.

1.0. SYSTEM COMPONENTS

The *DCS* is a *web-based* application operating as a customized graphical user interface. The application runs under Microsoft® *Internet Explorer (MSIE), Version 5.5, 6.0, or 7.0 or as directed by the Government*, and interfaces with tables that store the Duplicate Claims database. Access to the *DCS* will be through *MSIE, Version 5.5, 6.0, or 7.0 or as directed by* the Government.

2.0. HARDWARE AND SOFTWARE REQUIREMENTS

The requirements below are for user *personal computers (*PCs*)*, user printers, communications, software, and security.

2.1. *Hardware* Requirements

There are no specific minimum hardware requirements. As a general rule of thumb, the *requirements, as specified by the vendor for the specific version of MSIE should be followed. In addition, we suggest using a high bandwidth connection*.

2.2. Printer Requirements

Existing printers may be used for the *DCS*.

2.3. Communications Requirements

Contractors are required to connect the*ir hardware to* the *DCS through the Patient Encounter Processing and Reporting (PEPR) Portal using MSIE, Version 5.5, 6.0, or 7.0 or as directed by* the Government. The contractor must ensure that the connection has been tested.

2.4. Software Requirements

The software listed below must be installed and operational on each PC.

2.4.1. Operating System Software

No specific requirement.

2.4.2. Communications Software

MSIE, Version 5.5, 6.0, or 7.0 or as directed by the Government.

2.4.3. Application Software

No specific requirement.

2.4.4. Optional Software

Contractors may, at their own option and expense, procure and utilize full version database management software packages such as Microsoft Access®, dBase®, Paradox For Windows®, etc., on the *DCS* PCs for the purpose of generating customized queries and reports utilizing optionally downloaded *ASCII fixed-length files* that can be created by the *DCS*. Downloaded *ASCII fixed-length files* may also be imported into Microsoft Excel®.

2.5. Security Requirements

Security procedures require that all contractors identify a Security Manager to be responsible for overseeing the *DCS* registration process. *DCS* registration involves the submission of *one* security document, *for each user,* which may be copied from this chapter or obtained *through* the *Help Desk*. The *one* document *is*: *TRICARE DCS Account Activation Request* Form (Figure 9-9-1). Each *DCS* user must complete and sign the required form(s).

In order to access the *DCS*, users must obtain a User ID and an initial password from *the TRICARE Management Activity (*TMA*)*. User IDs and initial passwords will be issued following receipt *and processing* of properly completed registration and security forms. Contractor users should provide the required information, and submit the completed form to their *DCS* Security Manager for signature and transmittal to TMA.

DCS data must be encrypted. Encryption specifications will be provided by TMA. See the TRICARE Systems Manual *(TSM)*, Chapter 1 for additional security and communications requirements.

2.6. DCS Log-On And Password Procedures

2.6.1. Change Password

The following are the steps for users to log-on to the DCS and change their password.

2.6.1.1. *Passwords can be changed upon entering the PEPR Portal when the* ***Profile*** *link appears on the PEPR Portal Toolbar (in the upper right side of the screen). Click on the* ***Profile*** *link.*

2.6.1.2. *Select* ***Change Password*** *on the USER PROFILE SCREEN and follow the prompts. The* ***Change Password*** *form dialog box will appear.*

2.6.1.3. *The dialog box will ask the user to enter the old password, the new password, and retype the new password in the* ***Verify*** *box. Enter all three and click the* ***SUBMIT*** *button. If the User ID is*

*correct and the old, new, and verify passwords are correct, the message "**Password Successfully Updated**" will come back. See paragraph 2.6.4.*

2.6.1.4. *At the time of the login, i*f the User's password is due to expire in 15 *or less* calendar days, a message box will appear asking the user if they want to change their password now. If the user selects "No", they will be *sent* to the DCS. If the user selects "Yes", they will be *sent* to the *USER PROFILE SCREEN*. The *USER PROFILE SCREEN* will *have* a ***Change Password** option*.

2.6.1.5. The user should click on the ***Change Password** option* and the ***Change Password** form d*ialog *b*ox will appear.

2.6.1.6. The user should type in their old password and enter a new password twice. *See paragraph 2.6.4.*

2.6.1.7. After the user completes this process, they will be returned to the *"Welcome to the PEPR Portal" s*creen where they may click on the ***DCS** link that will send them to the "Welcome to the DCS System" screen*.

2.6.1.8. *The user should then click on the **Duplicate Claim System (DCS HCSR)** option. This will bring the user to the TRICARE DUPLICATE CLAIMS SYSTEM SCREEN where they can click on the **ACTIVE DATABASE**, **HISTORY DATABASE**, **TRAINING DATABASE**, or **EXIT** buttons.*

2.6.2. Password Expiration Notifications

2.6.2.1. *Passwords must be changed at least every 59 days or as otherwise specified by the government. Beginning 15 days before the password will expire, the user will be told the number of days before the password will expire, and be asked if they want to change the password now. If the user does not change the password by the last day, the User ID will be locked out, and the user must call the **Military Health System (MHS) Help Desk** to have the User ID re-installed.*

2.6.2.2. If a user's password has expired, the *system* will display a message box informing the user, "**Your password has expired.**" Please call the ***MHS*** **Help Desk** at **1-*800-600-9332***, *then follow* the prompt*s to* the DCS. *This will take the user to the San Antonio Help Desk.*

2.6.2.3. Users who have forgotten their passwords must call the ***MHS*** **Help Desk** at **1-*800-600-9332***, *then follow the prompts to the DCS*. *This will take the user to the San Antonio Help Desk.*

2.6.3. Password Process For New Users

2.6.3.1. Upon the receipt and processing of the required registration and security forms (see paragraph 2.7.), a TMA representative will notify the Security Manager or the user's supervisor of the new user's User ID and temporary password.

2.6.3.2. *Upon login to the PEPR Portal, t*he new user should now click on the ***Profile** link on the PEPR Portal Toolbar* which will bring up the *USER PROFILE SCREEN*. The new user should then click on the ***Change Password** option*. The DCS will then display the **Change Password** dialog box. The new user should then enter their temporary password *(old password)* and enter their new password twice *(new, verify)*.

2.6.3.3. Once the new password is accepted the new user will be taken to the *DCS ACCESS SCREEN* where they may click on the **ACTIVE DATABASE** or **HISTORY DATABASE** buttons to enter the DCS.

2.6.4. Password Specifications

2.6.4.1. Passwords must be at least *nine* characters long *and not greater than 12*.

2.6.4.2. Passwords must contain *all four character types with at least two of each of the following:* numbers, uppercase letters, lowercase letters, and special characters: **! @ # $ % ^ * ( ) _**.

2.6.4.3. Passwords must **not** contain any of the following special characters: **\ - ; : " ' / ~**.

2.6.4.4. A user may not re-use one of their last *12* passwords.

2.6.4.5. Passwords must be changed at least every *59* days *or as otherwise specified by the government*. *Beginning 15 days before the password will expire, the user will be told the number of days before the password will expire, and be asked if they want to change the password now. If the user does not change the password by the last day, the User ID will be locked out, and the user must call the* ***MHS Help Desk*** *to have the User ID re-installed.*

2.6.4.6. A user cannot change their password more than once in any 24 hour period.

2.6.4.7. Temporary passwords provided by TMA to new users, users whose passwords have expired, or to users who have forgotten their passwords must be changed immediately.

2.6.4.8. If a user attempts to log-on to the DCS with an incorrect password three consecutive times, their User ID will be locked and disabled and the user must call the ***MHS*** **Help Desk** at **1-*800-600-9332*** *(follow the prompts to the DCS, this will take the user to the San Antonio Help Desk)* to have their User ID unlocked.

2.7. Registration And Security Form - TRICARE *DCS Account Activation Request* Form (see Figure 9-9-1)

Each individual user must complete and sign the top portion of the TRICARE *DCS Account Activation Request* Form. The following are the required data elements to be provided by each user:

1. *System Access: Select from Web or Client/Server (C/S) Version*
   - *Select from Web or C/S Version*

2. *Employment Category*

3. *Applicant/Requestor Information*
   - *Rank/GS Level/Title:*
   - Name: (Last, First, MI)
   - *Complete Office Mailing Address*
   - *Sponsoring* Organization: *(Not Project Name)*

- *If Contractor, Employer Name* (Contractor Name, e.g., PGBA, Humana, TriWest, WPS, Health Net, etc.)
- *Commercial* Telephone *Number*: (include area code)
- *DSN*:
- User's e-mail address:
- *IP Address of Workstation (C/S only):*
- *Network Translated IP Address (C/S only):*
- *Account Validation PIN: (four digit numeric PIN to use when validating identity)*

4. Password Action/Access Authorization Requested
- *Check Action Requested: (Select New, Change, Delete, or Other with explanation)*
- *Enter User ID if the user already has one for the DCS*
- *Requested Access: Read Only; Read/Write (see 4.A.)*
- *Region Contractor Numbers: (62, 63, 64, 65, FO)*

4.A. Special Permissions Data for Read/Write Users (To be completed by requestor's supervisor)
- *Permission to create User Defined Codes? (Requires Prime Contractor approval)*
- *Permission to unarchive sets? (Requires Prime Contractor approval)*

5.A. Executive Information and Decision Support (EIDS) Security Awareness Training and Test (Not required for Managed Care Support Contractors (MCSCs))
- *Must have completed the EIDS Security Awareness Training and Test*
- *Must have signed and faxed the EIDS Security Awareness Certificate to EIDS*

5.B. Proof of Security Awareness Training (Required for MCSCs)
- *Must have a letter on file with EIDS verifying internal annual security awareness training requirements.*

6. Data Use Agreement (DUA) for Contractor (Not applicable for MCSCs)
MHS Contractor and/or non-MHS Employee must provide the following:
- *Employer Name:*
- *Project Description requiring this access:*
- *The DUA number for this project:*
- *Project period of performance:*

7. User Security Clearance Level (Mark the appropriate level)

8. TRICARE DCS Account Applicant Signature (All Applicants/Users must read and sign)
- User's Signature

Once the user has completed this portion of the form, it should be forwarded to the user's supervisor who can provide the permissions data in the *4.A.* block of the form. Supervisors should note that only certain users should be granted these permissions since execution of these functions will affect the data in the DCS and may increase the volume of sets required to be worked. Only experienced users should be granted these permissions.

Prime contractors should be careful when granting these permissions. The following information must be provided:

- Permission to create User Defined Codes? (A "Yes" requires written or verbal approval from the Prime contractor. The supervisor should obtain the Prime contractor's approval. TMA will verify a "Yes" answer with the Prime contractor.)

- Permission to unarchive sets? (A "Yes" requires written or verbal approval from the Prime contractor. The supervisor should obtain the Prime contractor's approval. TMA will verify a "Yes" answer with the Prime contractor.)

- Supervisor's signature.

- Supervisor's telephone number.

Once the supervisor has completed this portion of the form, it should be forwarded to an individual (preferably an Information Technology Representative) who can provide the Site Hardware and Communications Data in the third block of the form. The following information must be provided:

- *Connection established to PEPR Portal*? (The answer to this question must be "Yes" before a User ID will be issued. "Yes" verifies that the PC can establish communication with the TMA server. See paragraph 3.0., for server address.

- Location of computer: (building number, unit name, etc.)

Once this portion has been completed the form should be forwarded to the Contractor Security Manager for review and signature.

3.0. CONNECTIVITY

Connectivity will be through the internet to the PEPR Portal via MSIE, Version 5.5, 6.0, or 7.0 or as directed by the Government.

4.0. SYSTEM SUPPORT

4.1. For *DCS* support, contractors should call the ***MHS*** **Help Desk** at **1-*800-600-9332***, *then follow the prompts to the DCS*. *This will take the user to the San Antonio Help Desk*.

4.2. System upgrades will occur automatically when users sign on to the system.

5.0. SYSTEM INSTALLATION AND TRAINING

5.1. Contractor Installation Responsibilities

Contractors are responsible for installing the *MSIE*, *Version 5.5, 6.0, or 7.0 or as directed by the Government, and Adobe Reader, on their hardware*, and *establishing* connectivity to the *PEPR Portal*. In addition to the communications software required to establish connectivity to

the *web-based DCS*, contractors are responsible for installing their preferred operating system on the*ir hardware*.

5.2. Training

TMA will provide training to prospective users of the *DCS*. *The training may be on-line or in person at a central location.* TMA will coordinate with each contractor *once the approach is defined*.

6.0. CONTRACTOR POINTS OF CONTACT *(POC)*

To resolve multi-contractor duplicate claim sets, contractors are required to communicate and coordinate with each other (see *Section 6*). For each regional contract for which a contractor is responsible, the contractor is required to identify at least one individual to serve as the *DCS* POC. Contractor POCs must be individuals who are, or will be, trained in the use of the *DCS*, and are able to perform the required research and determine whether a particular claim is within their processing jurisdiction. For each regional contract for which they are responsible, contractors shall provide the name(s), title(s), business address(es), and business telephone number(s) of their *POC*(s) to the Contracting Officer *(CO)*, with courtesy copies to the Contracting Officer Representatives (CORs) and to the TMA DCS Program Representative. The POCs shall be provided to the *CO* no later than *(NLT)* two weeks prior to implementation of the *DCS*.

Prior to system implementation, TMA will provide each contractor with the list of all *DCS* POCs. Whenever a new contract is awarded, TMA will notify all contractors of the new contractor's POC. Once the initial listing is provided to the contractors, it is the responsibility of each contractor to maintain the listing and keep TMA and the other contractors informed of any changes.

7.0. OPERATING PROCEDURES

For each regional contract for which a contractor is responsible, or for the TRICARE Dual Eligible FI Contract (TDEFIC), the contractor shall develop internal operating procedures for the *DCS*. These internal operating procedures shall designate the responsible areas for the various duplicate claims resolution functions and establish time lines. For example, one contractor may decide that the adjustment unit shall be responsible for scanning the *DCS* on a weekly basis for the appearance of adjustments submitted and for closing sets. Another contractor may decide that the unit responsible for researching potential duplicate claims should also be responsible for scanning for adjustments and closing the sets on a daily basis.

Contractor contract requirements for overpayment recovery, refunds and offsets, adjustments, etc., including timeliness requirements, apply to the operation of the *DCS*. As a result, operating procedures must be developed which are consistent with all applicable contract requirements. Procedures must be established to ensure that recoupments are initiated in a timely manner following the research determination that a duplicate payment had been made. In other words, procedures must specify that after a decision has been made by the person responsible for determining that a duplicate payment was made, recoupment

must be initiated in a timely manner and must be consistent with all overpayment recovery timeliness standards.

Contractors shall develop these procedures within 60 days of the date of system implementation and have them available for TMA review.

8.0. CONTRACTOR PERFORMANCE REQUIREMENTS

8.1. Contractors shall use the TRICARE *DCS* to resolve TMA identified potential duplicate claims payments.

8.2. Contractors shall move *Open* status potential duplicate claim sets to *Pending*, *Validate*, or *Closed* status on a first-in/first-out basis. To this end, contractor performance will be measured against the percentage of claim sets in *Open* status at the end of a month with Current Load Dates over 30 days old. No more than 10% of the potential duplicate claim sets remaining in *Open* status at the end of a month shall have Current Load Dates over 30 days old. Contractor compliance with this standard shall be determined from the Performance Standard Report generated by the *DCS* (see *Addendum E*, Summary Management Report titled "Performance Standards", for a description and example of the Performance Standard Report). The 10% standard becomes effective on the first day of the seventh month following the start of services or following system installation whichever is later.

8.3. Contractors shall not be responsible for meeting the performance standard during any month in which availability of the *DCS* is prevented for two working days due to failure of any system component for which the Government is responsible. The Government is responsible for: TMA servers on which the *DCS* data resides; Government-supplied communications lines, if any; Government-supplied routers, if any; Government-supplied *Channel Sending Unit (*CSU*)/Data Sending Unit (*DSU*)* equipment that connect the routers to the communication lines, if any; and the *DCS* application software.

8.4. Contractors are responsible for their own PCs, printers, PC operating system software, and in-house communications software and equipment, including in-house *Wide Area Network (*WAN*)/Local Area Network (*LAN*)* equipment, circuits, and routers. Contractors are responsible for any contractor-supplied communication lines, contractor-supplied routers, and contractor-supplied CSU/DSU equipment that connect the routers to the communication lines. Contractors are responsible for contractor-supplied internal and external networks, network connections to the routers, firewalls, and all software (including operating system, application, and network software) other than the *DCS* application-related software. Contractors are required to install and maintain PCs with *MSIE, Version 5.5, 6.0, or 7.0 or as directed by the Government; and Adobe Reader.* Contractors are responsible for maintaining their own networks, including hardware and software (other than the *DCS* software). TMA will fully support the *DCS* application software.

8.5. All overpayment recovery, refund, offset collection and adjustment requirements, including timeliness standards, are applicable to the operation of the *DCS*.

9.0. TRANSITIONS

The date when an incoming contractor will assume full responsibility for resolving all existing potential duplicate claim sets from the outgoing contractor (including completing existing recoupments), and for all new potential duplicate claim sets, shall be determined during transition meetings and be established in the transition plan/schedule. The criteria for the types of claims for which the outgoing contractor will retain responsibility (e.g., financially underwritten/non-financially underwritten claims), and the types of claims to be transferred to the incoming contractor, will also be defined in the transition plan/schedule.

FIGURE 9-9-1 TRICARE DCS ACCOUNT ACTIVATION REQUEST FORM

TRICARE Duplicate Claims System Account Activation Request Form

See Pages 5-6 for Form Instructions and Guidance

Upon Completion of this Form Including Block 9 & Attachment A, Fax to 303.676.3979

1. System Access (Please check the system for which you have mission/contract related access requirement)	
	DCS - Web Version DCS
	Client/Server (C/S) Version

2. Employment Category (Please check the category that applies)	
	Government Employee, Uniformed Service Member, Military, or Civil Service working within/for DoD MHS
	Contractor working within the DoD Military Health System
	Government Employee, Uniformed Service Member, Military, or Civil Service working for other agency or directorate not a part of the DoD Military Health System
	Contractor working for Government Agency, not a part of the DoD Military Health System
	Other (Please describe) _____

3. Applicant/Requestor Information	
Rank/GS Level/Title:	
Name (Last, First, MI):	
Complete Office Mailing Address:	
Sponsoring Organization Name: (Not Project Name)	
If Contractor, Employer Name	
Commercial Telephone Number:	
DSN:	
Email:	
IP Address of Workstation (Client Srvr only)**:**	
Network Translated IP Address (Client Srvr)**:**	
Account Validation PIN: Enter a 4 digit numeric PIN that you will use to validate your identity for account administration purposes. **This must be the same number as entered when registering in the EIDS WebPortal.**	

4. Password Action/Access Authorization Requested

Check action requested: ❑ NEW ❑ CHANGE ❑ DELETE ❑ OTHER _____

If you have a User ID, please enter it here: _____ (If your account has expired, enter your last user ID)

Requested Access: ❑ **READ ONLY** ❑ **READ/WRITE (supervisor must complete 4.A., below)**

Requesting Access to following contractor region number(s)*: _____

* If access to multiple contractor regions is required, all region contractor numbers must be specified.

4.A. Special Permissions Data for READ/WRITE Users (To be completed by requester's supervisor)

Permission to create User Defined Codes? (Requires Prime Contractor approval): ❑ YES ❑ NO

Permission to unarchive sets? (Requires Prime Contractor approval): ❑ YES ❑ NO

Supervisor Signature: _____ **Phone#:** _____

Prime Contractor Signature: _____ **Phone#:** _____

Version 12/6/06 - All previous versions are OBSOLETE

Page 1

FIGURE 9-9-1 TRICARE DCS ACCOUNT ACTIVATION REQUEST FORM (CONTINUED)

5.A. EIDS Security Awareness Training and Test (Not required for MCSCs)

1. Have you successfully completed the EIDS Security Awareness Training and Test? ❑ YES ❑ NO
2. Have you signed and faxed the EIDS Security Awareness Certificate to EIDS? ❑ YES ❑ NO

5.B. Proof of Security Awareness Training (Required for MCSCs)

1. Is a letter on file with EIDS verifying internal annual security awareness training requirements? ❑ YES ❑ NO

6. Data Use Agreement (DUA) for Contractor (Not applicable for MCSCs)

If you are an MHS Contractor and/or non-MHS Employee, please provide the following information:

Employer Name:	
Project description requiring this access:	
What is the DUA # that exists for this project?	
Project period of performance:	

7. User Security Clearance Level (mark appropriate level):

	ADP II	Notes: 1. A minimum of ADP Level II is required. 2. The use of SECRET is authorized if the requestor's clearance has been active within 2 years of application date.
	ADP I	
	Other (specify) Type _____ Date _____	
	If SECRET, provide: Date of Birth: _____ Place of Birth: _____	

8. TRICARE DCS Account Applicant Signature (All Applicants/Users must read and sign)

By signing below, I am acknowledging that (1) all statements made on this form are true and correct; and (2) I am only authorized to use TRICARE DCS for my current position/duty and agree to relinquish my TRICARE DCS accounts to the EIDS Program Office upon departure from my current position/duty. I understand and accept that my use of the system may be monitored as part of managing the system, protecting against unauthorized access and verifying security problems. I further acknowledge that substantial civil and criminal penalties including fines up to $50,000 and one year imprisonment, and/or administrative sanctions may be levied against those who violate the provisions of the Privacy Act of 1974 and/or the Health Information Portability and Accountability Act (HIPAA) of 1996.

Signature _____ **Date** _____

ALL APPLICANTS MUST ALSO COMPLETE AND SIGN ATTACHMENT A (PAGE 4)

9. Commander, Supervisor, or Security Officer Certification of Citizenship

By signing below, I am certifying that _____ (applicant) is a U.S. Citizen and has a mission essential or contract-driven requirement to access DCS, and that the DUA referenced, if any, is applicable. I further acknowledge that substantial civil and criminal penalties including fines up to $50,000 and one year imprisonment, and/or administrative sanctions may be levied against those who violate the provisions of the Privacy Act of 1974 and/or the Health Information Portability and Accountability Act (HIPAA) of 1996. I shall notify the EIDS Program Office upon departure of this applicant from their current position/duty or when access is no longer required.

Commander/Supervisor/Security Officer Name	
Title or Position	
Organization, Office, Company	
Office Mailing Address:	
Email Address	
Commercial Telephone	
DSN	

Signature _____ **Date** _____

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FIGURE 9-9-1 TRICARE DCS ACCOUNT ACTIVATION REQUEST FORM (CONTINUED)

UPON COMPLETION OF BLOCK 9 AND ATTACHMENT A, FAX THIS FORM TO 303-676-3979.

10. Government Sponsor (usually TMA)	
Sponsoring Organization Name	TMA - Purchased Care Systems Branch
Commander / Supervisor / Sponsor Name (Last, First, MI)	
Title	
Office Mailing Address	16401 E Centretech Pkwy Aurora, CO 80011-9066
Email Address	
Commercial Telephone	
DSN	
Access Level Approved	❑ Read Only ❑ Read/Write ❑ R/W/Admin
Unarchive Sets?	❑ Yes ❑ No
Create User Defined Codes?	❑ Yes ❑ No
Contractor Region Numbers Granted	

Government Sponsor Signature _____ **Date** _____

DO NOT WRITE BELOW THIS BOX

11. EIDS Certification (For EIDS use only)	
❑ Form ❑ SAC ❑ WPValidPIN ❑ AppSigned ❑ CertSigned ❑ SponSigned EIDSAccess _____ ❑ NTK _____	
I certify that EIDS requirements have been validated. Specified access is recommended.	
EIDS PO Approving Authority Name	

Signature _____ **Date** _____

12. TMA Privacy Office Approval (For TMA use only)

I certify that the applicant has ❑ has not ❑ met the requirements for ADP/IT security levels of trust; and

Has an approved DUA on file with the TMA Privacy Office ❑ YES ❑ NO ❑ N/A (Government & Military); and

Is a U.S. Citizen ❑ or has provided proof of U.S. Citizenship as required. ❑

That the access level and justification is ❑ is not ❑ appropriate for their system use.

The Privacy Office approves ❑ does not approve ❑ the request for access to the MHS system.

HPA&E, TMA Privacy Office

Signature _____ Date _____

Email Address **dua.mail@tma.osd.mil**

13. User ID Creation (EIDS SysAdmin creates AIX ID, TMA-Aurora creates Portal ID and DCUSER entry)

PEPR Portal ID created (Web Only):	_____	Signature: _____	Date: _____
AIX ID Created (C/S Only):	_____	Signature: _____	Date: _____
DCUSER ID Created (All):	_____	Signature: _____	Date: _____

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FIGURE 9-9-1 TRICARE DCS ACCOUNT ACTIVATION REQUEST FORM (CONTINUED)

Attachment A

Justification for Access to Protected Health Information (PHI)

(Required for DCS access)

Generally speaking, only healthcare providers involved in the treatment of patients are allowed access to patient-identifying data regarding patients under their care. Such access could also extend to healthcare managers and administrative support personnel with specific, defined roles regarding paying or receiving reimbursement on medical claims and essential activities in support of health care operations. The use or disclosure of protected health information outside these parameters and without the patient's consent may violate the Privacy Act of 1974 and/or the Health Insurance Portability and Accountability Act of 1996 (HIPAA). A more detailed description regarding the required protection of individually identifiable data is available at **http://www.usdoj.gov/04foia/privstat.htm** and **http://www.tricare.osd.mil/hipaa/**.

Please identify your requirements for access to patient identifiable data.

_____

_____

_____

Privacy Act

Some data are protected under the provisions of the Privacy Act of 1974. The data contains patient and provider identity information and thus requires safeguards from unauthorized access and use. I agree to comply with the Privacy Act of 1974 and to be responsible for the use of this data to properly safeguard patient and provider identifying data in accordance with the 30 Oct 2001 OASD(HA) memorandum signed by Major General Randolph, Deputy Executive Director TMA, subject "*Supplemental Guidance for the Management and Control of Patient Sensitive/Medical Record Information in the Military Health System.*" In addition, I acknowledge that I may be subject to civil suit under the Privacy Act or 1974 for damages which occur as a result of willful or intentional actions which violate an individual's rights under the Privacy Act of 1974.

Protected Health Information (PHI)

I accept responsibility for the PHI data in DCS that is in my possession and will ensure that all reasonable efforts are made in order to protect the data from unauthorized access and misuse.

HIPAA

I acknowledge that under HIPAA (P.L. 104-191), Congress has established criminal penalties for knowingly violating patient privacy. Criminal penalties are up to $50,000 and one year in prison for obtaining or disclosing protected health information; up to $100,000 and up to five years in prison for obtaining protected health information under "false pretenses"; and up to $250,000 and up to ten years in prison for obtaining or disclosing protected health information with the intent to sell, transfer or use it for commercial advantage, personal gain or malicious harm.

User Signature _____ **Date** _____

Printed Name _____

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FIGURE 9-9-1 TRICARE DCS ACCOUNT ACTIVATION REQUEST FORM (CONTINUED)

Instructions and Guidance for
TRICARE Duplicate Claims System Account Activation Request Form

1. **System Access.** Select which DCS system you wish to access.

Overview of the System

DCS	The TRICARE Duplicate Claims System (Duplicate Claims System or 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) or TRICARE Encounter Data (TED) database. The system also generates operational and management reports.

2. **Employment Category.** Check category that applies.

3. **Applicant/Requestor Information.** Please fill in all applicable fields. "IP Address of Workstation" and "Network Translated IP Address" are only required for accounts being created for the Client/Server version of DCS. You must select a 4-digit Account Validation PIN. It may be any 4-digit number that you will remember if needed to verify your identity for account administration purposes (i.e. password reset). For instance, you may use the last 4-digits of your social security number or month and day of birth, etc. This number must be the same as the Account Validation PIN you have entered at the EIDS WebPortal: http://eids.ha.osd.mil and as provided for other EIDS systems, as applicable.

4. **Password Action/Access Authorization Requested.** Check to indicate whether this is a request for a new DCS user account or an account or password change, account deletion or reactivation. If you have a user ID, please provide it. If your account has expired, please provide your last user ID if known.

4.A. **Special Permissions Data for Read/Write Users.** Select the various special permissions required for your mission or contract related work. These special permissions must be approved by your supervisor and prime contractor.

5.A. **EIDS Security Awareness Training and Test (all applicants except MCSC).** DoD Directive 8500.2, "Information Assurance (IA) Implementation" requires that information system users complete Security Awareness Training on an annual basis. In accordance with this directive, the EIDS Program Office must have a copy of your Security Awareness Certificate on file.
If you have not completed online Security Awareness training in the past year, you will need to take the training, complete the quiz, download the form, sign it and send it via fax to EIDS Access at **866-551-1249**. The Security Awareness Certification can be accessed on the MHS Help Desk area of the EIDS Web site (**http://eids.ha.osd.mil**). See **How to Access the Security Awareness Training Manual and Test** on page 6 for step by step instructions on how to access the EIDS Web site and take the Security Awareness Test. You may also contact the MHS Help Desk by phone at 800-600-9332 for assistance.

5.B. **Proof of Security Awareness Training (MCSC personnel only).** The EIDS Security Awareness Training Certification is not required for MCSC personnel. A letter of proof of security awareness training must be on file with EIDS verifying internal annual security awareness training requirements were met.

6. **Data Use Agreement (DUA) Number (not applicable for MCSC personnel).** Non-MHS personnel (generally other DoD employees) and/or contractors working for the MHS/DoD requiring access to DCS data are required to have a current Data Use Agreement on file with the TRICARE Management Activity (TMA) Privacy Office. For information pertaining to Data Use Agreements, please refer to the TMA Privacy Office website at **http://www.tricare.osd.mil/tmaprivacy/**.

7. **Security Clearance Level.** All users of DCS must have a minimum security clearance of ADP Level II. Users should contact their organization's Security Officer or Personnel Office for assistance. For further assistance or direction on applying for an ADP II clearance, send an email to the TMA Privacy Office at **dua.mail@tma.osd.mil**.

FIGURE 9-9-1 TRICARE DCS ACCOUNT ACTIVATION REQUEST FORM (CONTINUED)

8. **DCS Account Applicant Signature.** All applicants must sign this form to verify the truth and accuracy of the information provided and understanding of the responsibility undertaken if requested system access is granted.
9. **Commander, Supervisor or Security Officer Certification of Citizenship.** The requestor's commander, supervisor, or security officer (the requestor's employer) must certify that the requestor is a U.S. Citizen and has a mission or contract related requirement to access the DCS. All fields must be completed. Signature is required.

Once Block 9 is complete, fax form to TMA - Purchased Care Systems Branch: 303-676-3937. Include Attachment A in your submission for access to PHI if required.

10. **Government Sponsor.** All fields must be completed. The Government Sponsor's signature is required.

Once Block 10 is complete, fax form to EIDS Access: 866-551-1249. Include Attachment A in your submission, if required.

11. **EIDS Certification.** For EIDS use only.

12. **TMA Privacy Office Approval.** For TMA Privacy Office use only.

13. **User ID Creation.** For TMA use only.

Attachment A. Justification for Access to Patient Identifiable Data.

All users require justification for access to the protected health information contained in DCS.
User justification and signature is required.

How to Access the Security Awareness Training Manual and Test

1. Log onto the EIDS Web portal at **http://eids.ha.osd.mil**

Note: If you do not have an EIDS Web account, follow these steps:

A. At the EIDS Web site, select **Register** from the horizontal menu bar.
B. Complete the registration form and click **Register**.
C. Make note of your EIDS Web site account information.
D. Click **Login** from the EIDS Web site and log in using your new EIDS Web account.

2. Click **MHS Help Desk** from the horizontal menu bar.
3. Read the Security Awareness Training Manual, and then take the Security Awareness Training Test.
   (a) Click on **Take the Security Awareness Training Exam**, listed at the end of the Security Training Manual; or
   (b) Click on **Security Awareness Training: Take the Test** from the MHS Help Desk screen.
4. Upon successful completion of the test, you are presented with an EIDS Security Awareness Certificate. Scroll to the bottom of the Certificate and download using the indicated link.
5. Per the form's instructions: print, sign, and fax the form to the EIDS Program Office, ATTN: EIDS Access at 866-551-1249.

KEEP A COPY OF THIS FORM IN A SAFE PLACE FOR YOUR RECORDS AND FUTURE REFERENCE.

CHAPTER 9
ADDENDUM A

DUPLICATE CLAIMS SYSTEM DISPLAYED DATA FIELDS

HCSR DATA ELEMENTS	
FIELD NAME	**DESCRIPTION**
Sponsor SSAN	Sponsor Social Security Number
DOB	Patient Date Of Birth
DDS	DEERS Dependent Suffix Code (DDS)
Program Ind	Program Indicator Code
Provider Tax ID	Provider Taxpayer Number
Provider Sub ID	Multiple Provider ID
Proc Code/Proced Code	Procedure Code
Diagnosis	Principle Treatment Diagnosis Code
DRG	Diagnosis Related Group Number
Inst Admit Date	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
Type Serv	Type Of Service
PTC Date	Processed To Completion Date
HCSR ICN	Internal Control Number
Suffix/SFX/S	Control Number Suffix
Time Stamp	System time assigned when issuing an initial HCSR
Proc FI	HCSR FI Contractor Number

HCSR DATA ELEMENTS (CONTINUED)	
FIELD NAME	**DESCRIPTION**
Processing Contract	Contract Number
Batch Sequence #	Batch Sequence Number
Voucher Sequence #	Voucher Sequence Number
Cycle Number	TMA Processing Cycle (Year, Month, Cycle Number)
Name	Patient Name
Age	Patient Age
Enrolled	Enrollment Status
Patient Zip Code	Patient Zip Code
Provider Zip Code	Provider Zip Code
Provider Affiliation	Provider Contract Affiliation Code
Provider Specialty	Provider Specialty Code
Type Institution	Type Of Institution Code
Disp	Discharge Disposition
Govt Pd Amount	Amount Paid By Government Contractor
L	Claim Line Item Number
HCSR Line #	Non-Inst Adjustment Line Item Number; For Inst = 00
Adjust PTC Date	Adjustment Processed to Completion Date
Allowed Amount	Claim Level Adjustment Allowed Amount for Institutional Claim Line Item Level Adjustment Allowed Amount for Non-Institutional Claim
Special Processing Code 1	First Special Processing Code
Special Processing Code 2	Second Special Processing Code
Special Processing Code 3	Third Special Processing Code
Special Rate Code	Special Rate Code
Pricing Code	Pricing Code On Non-Institutional Line Item
CPT-4 Modifier 1	
CPT-4 Modifier 2	

GENERATED DATA ELEMENTS	
FIELD NAME	**DESCRIPTION**
Set #	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.
Risk	Financially underwritten, non-financially underwritten indicator for claim. *Please note that for the purposes of this system:* *Financially underwritten = Risk* *Non-financially underwritten = Not-at-risk.*
Mass Change Level	The latest MASS CHANGE cluster rule applied to the claim.
Patient Region	Patient health service region code.
Provider Region	Provider health service region code.
Owner FI	**Owner FI** represents, for the claim set, the 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 (**Resp FI**), in which case the **Owner FI** 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 **Owner FI** is originally assigned by the system to be the responsible FI/Contractor from the claim within the set having the latest processed-to-completion date.
Resp FI / Rsp FI	**Resp FI** or **Rsp FI** represents, for the claim, the contractor that is currently responsible for administering the claim. When the claim is initially extracted from HCSR, the **Resp FI** is identical to the **Proc FI** (Processing FI). However, contract awarding and transitions may require claim administration by a new contractor, in which case the system will assign a new **Resp FI** for the claim.

GENERATED DATA ELEMENTS (CONTINUED)	
FIELD NAME	**DESCRIPTION**
Owner Region	**Owner Region** is a narrative descriptor of the contract number and represents, for the claim set, the Owner FI/ Contractor region. Typically, all claims within a set will have the same **Responsible Contract**, in which case the **Owner Region** will be the same as the **Responsible Contract**. However, for multi-contractor claim sets where the contractors are not the same for all claims within the set, an **Owner Region** is assigned by the system to be the **Responsible Contract** from the claim within the set having the latest processed-to-completion date. The initial assignment is done in tandem with the assignment of **Owner FI**.
Responsible Contract	**Responsible Contract** represents, for the claim, the contract under which the claim is currently administered. When the claim is initially extracted from HCSR, the **Responsible Contract** is identical to the **Processing Contract**. However, contract awarding and transitions may require claim administration under a new contract, in which case the system will assign a new **Responsible Contract** for the claim.
Dupe?	**Dupe?** is an indicator to describe whether or not the claim is a duplicate. During the extract processes **Dupe?** 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 **Dupe?** 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*.]
Reason Code	**Reason Code** 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 **Dupe?** being set to "N") a reason code of BASE 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 explanation field for further elaboration.

GENERATED DATA ELEMENTS (CONTINUED)	
FIELD NAME	**DESCRIPTION**
HCSR Adjust?	**HCSR Adjust?** 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 HCSR Adjustment field is the sum (for the claim) of allowed dollar amounts for those that apply. Display screens enable **HCSR Adjust?** to be checked for any institutional claim and any non-institutional line item.
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	**Identified Recoup** 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	**Actual Recoup** 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.
HCSR Adjustment	**HCSR Adjustment** 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 (**Allowed Amount**) that have been flagged by the user as being associated with correcting the duplicate. This is the sum of claim level allowed amounts for institutional claims and line item allowed amounts for non-institutional claims.
ID Recoup	**ID Recoup** is a dollar amount calculated by the system as the sum of **Identified Recoup** amounts for all claims within a set. It represents the total amount of overpayment for the claim set that has been identified for recoupment.
Actual Recoup	**Actual Recoup** is a dollar amount calculated by the system as the sum of claim level actual recoupment amounts for all claims within a set. It represents the total amount of overpayment for the set that has actually been recouped.
Adjust Amount	**Adjustment Amount** is a dollar amount calculated by the system as the sum of **HCSR Adjustment** 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.

GENERATED DATA ELEMENTS (CONTINUED)	
FIELD NAME	**DESCRIPTION**
Initial Load Date	**Initial Load Date** represents the date the claim set was initially loaded into the system. The LASTDATE reflects the most recent claim set update date - for specific types of updates.
Current Load Date	**Current Load Date** 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.
Last Update Date	**Last Update Date** represents the most recent date a claim set was updated. Changes to the following **will** change the **Last Update Date**: Status, Match Type, Multi-FI Indicator, Owner FI, Owner Region, ID Recoup, Actual Recoup, Set Adjustment Amount, and Adjust Indicator. The **Last Update Date** will **not** change solely due to a change to: User Defined Codes, Dupe? field, Solicited (S?) Indicator, HCSR Adjust?, Reason Code, Reason Code Explanation, or Notepad.
S?	**S?** is the Solicited Indicator. See *Section 5* for definition.
Set Level User Defined Code	See *Section 5* for definition.

CHAPTER 9
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
D103	Offset - Reissue	The duplicate payment was a result of an offset being cancelled and a new payment reissued.	No
D104	Stop Pay - Reissue	This duplicate payment was a result of the original check being stopped and the payment reissued.	No
D105	Stale Date - Reissue	This duplicate payment was a result of the original check stale dating and the payment reissued.	No
D200	System failed to detect and suspend as a potential duplicate.	The system did not recognize the claim as a potential duplicate.	Yes

REASON CODE	DESCRIPTION	EXPLANATION	ADDITIONAL EXPLANATION REQUIRED?
ACTUAL DUPLICATE REASON CODES (CONTINUED)			
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
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 TMA data base.	Yes
D208	Paid wrong provider.	The duplicate payment was a result of the initial payment being made to the wrong provider.	No
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 contractor.	No

REASON CODE	DESCRIPTION	EXPLANATION	ADDITIONAL EXPLANATION REQUIRED?
ACTUAL DUPLICATE REASON CODES (CONTINUED)			
D400	*TFL - Paid Primary in Error*		*No*
D401	*TFL - Dup logic failed to ID*		*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	Same procedure codes/ different provider types (e.g., surgeon/assistant surgeon).	This is not a duplicate payment since the services paid on this claim are for assistant surgeon services were rendered by a different type of provider than the type of provider paid on the other claim(s).	No
N107	ECHO prorated Durable Equipment (DE)	This is not a duplicate payment since the services paid on this claim are for different ECHO prorated DE than that paid on the other claim(s).	No
N108	Technical or facility component/ professional component.	This is not duplicate payment since the services paid on this claim involve the technical or facility/professional services not paid on the other claim(s).	No

REASON CODE	DESCRIPTION	EXPLANATION	ADDITIONAL EXPLANATION REQUIRED?
NON-DUPLICATE REASON CODES (CONTINUED)			
N109	Same procedure codes but 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
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
BASE	*Initial submission*		*No*

REASON CODE	DESCRIPTION	EXPLANATION	ADDITIONAL EXPLANATION REQUIRED?
NON-DUPLICATE REASON CODES (CONTINUED)			
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 issued to pay a different provider, or it reflects a payment issued under a previous suffix and a cancellation of the previous suffix has been issued or will be issued for the previous suffix, it is still a duplicate payment and the claim should be assigned "Y" **Dupe?** and an "Actual Duplicate Reason Code" used.	Yes
N300	Claim belongs to FI 99	The claim belongs to FI 99. This non-duplicate reason code may be used to enable resolution of a set where the FI 99 claim is not the BASE claim. If the FI 99 claim is the BASE claim, the other claim(s) may be flagged with "Y" or "N" **Dupe?** and reason codes, recoupment amounts entered, and corresponding adjustments flagged as usual. If the FI 99 claim is not the BASE claim, it should be flagged with an "N" **Dupe?** and an N300 reason code. In either case, no FI 99 adjustments should be flagged.	No
N900	Other		Yes

CHAPTER 9
ADDENDUM C

INCOMING CONTRACTOR SUPPORT OF BOTH HCSR AND TED VERSIONS OF THE TRICARE DUPLICATE CLAIMS SYSTEM

This addendum describes the requirements for incoming contractors to operate both versions of the TRICARE Duplicate Claims System (DCS), that is, the *Health Care Service Record (*HCSR*)* and *TRICARE Encounter Data (*TED*)* versions.

1.0. REQUIREMENTS FOR USE OF THE HCSR VERSION OF THE DCS

1.1. For incoming contractors, the TED version of the DCS will be their primary version. This is because the incoming contractors will be creating and submitting TED records and not HCSRs. However, incoming contractors will be inheriting, in accordance with the transition plans, non-*networked DCS* sets from the outgoing contractors. These inherited sets are comprised of HCSRs, not TEDs. *The TRICARE Management Activity (*TMA*)* is not converting HCSRs to TEDs. As a result, the incoming contractors must operate the HCSR as well as the TED version until all HCSR-related DCS actions are completed. It should be noted that TMA will be converting TED adjustment records to HCSRs. This permits the incoming contractor to adjust previously submitted HCSRs through a TED record.

1.2. In accordance with the DCS Contractor to Contractor Transition Guide in Addendum D, on the first day of the fourth month following the start of Services, TMA will initiate a mass change of the outgoing contractor's DCS sets. This mass change will transfer all of the outgoing contractor's non-*networked* DCS sets (and any other DCS sets identified in the transition plan) to the incoming contractor. The sets transferred to the incoming contractor may contain sets in *Open* status, as well as sets in *Pending*, *Validate*, and *Closed* status. Any transferred sets in *Open* status must be researched by the incoming contractor and determinations made as to whether actual duplicate payments were made. Recoupments must be initiated on all claims identified as actual duplicates. This means that the incoming contractor must be able to read the HCSR data files transferred from the outgoing contractor by the first day of the fourth month following the start of Services in order to perform the required research and recoupments for sets appearing in the HCSR version of the DCS.

1.3. Any set in *Pending* or *Validate* status are awaiting recoupment. The incoming contractor will likely inherit such sets from the outgoing contractor. The outgoing contractor shall have forwarded all payment and recoupment files associated with in-progress non-*networked* duplicate claim recoupments by the last day of the third month following the start of Services. Any refunds or offsets received by the incoming contractor that are associated with claims in *Pending* or *Validate* sets that were inherited, shall be entered into the HCSR version of the DCS. By the first day of the fourth month following the start of Services, the incoming contractor should have received and have access to all of the HCSR data and recoupment information necessary to work these sets.

1.4. For any refund or offset applied to claims in any inherited DCS set, the incoming contractor must submit an adjustment or cancellation TED record for a previously submitted

HCSR. When TMA receives an adjustment or cancellation TED for a previously submitted HCSR record, it will convert it to a HCSR and load it to the HCSR version of the DCS. The incoming contractor will then be able to apply the adjustment to the claim in the set and resolve the set, if the rules of resolution are met.

1.5. Incoming contractors should expect to see new multi-contractor sets in the HCSR version. These multi-contractor sets are created when a HCSR from an existing contractor "dupes out" with a HCSR whose ownership has been transferred and inherited by the incoming contractor.

1.6. TMA will not be comparing TED submissions with HCSR submissions to identify new potential duplicate payments. In other words, TED records submitted by the incoming contractor will not be matched with HCSRs currently or previously submitted by existing contractors. TED records will only be compared against other TED records. Also, any TED records converted to HCSRs will not be compared with other HCSRs for new potential duplicates. Only TED adjustments to previously submitted HCSRs will be loaded to the HCSR version of the DCS. These adjustments can then be used to resolve existing sets.

1.7. Incoming contractors should expect to see diminishing activity in the HCSR version of the DCS as existing contracts are transitioned to new incoming contractors. Once all contracts have been transitioned and all payment records are submitted in TED format, and all non-*networked* sets have been resolved to a *Validate* or *Closed* status, the HCSR version will be retired and only the TED version will be used.

CONTRACTOR TO CONTRACTOR TRANSITION GUIDE

DATES	OUTGOING CONTRACTOR	TMA	INCOMING CONTRACTOR
Contract Award Through Start of Services	Continues to use the DCS to resolve potential duplicate claim sets.	Loads identifying and other information regarding the incoming contractor, the contract and region into the DCS. 30 - 45 days prior to the start of Services, TMA installs DCS software and trains the incoming contractor staff on the use of the DCS.	Purchases, configures and tests computer hardware, software and communications links required to operate the DCS no later than 60 days prior to the start of Services.
Start of Services Through The Last Day of The Third Month Following The Start of Services (3 months)	Continues to use the DCS to resolve potential duplicate claim sets.	TMA begins the ongoing process of identifying and loading potential duplicate claim sets associated with the incoming contractor. Within 60 days following Services, TMA prepares a "mass change" specification form which is to be executed on the first day of the fourth month after Services, for a "mass change" to transfer all potential duplicate claim sets involving **non-*networked*** claims from the outgoing contractor's DCS to the incoming contractor's DCS.	Incoming contractor begins using the DCS to resolve identified potential duplicate claim sets "owned" by the incoming contractor.
Note: This schedule shall be incorporated into the transition plans for the outgoing contractor and the incoming contractor. Actual dates shall be established in the transition plans.			

DATES	OUTGOING CONTRACTOR	TMA	INCOMING CONTRACTOR
Last Day of The Third Month Following The Start of Services	At the close of business, the outgoing contractor shall **cease** researching non-***networked*** *Open* claim sets and initiating new recoupments associated with non-financially underwritten duplicate claim payments. The outgoing contractor shall also **cease** entering refund data and linking adjustment data in the DCS for *Pending* and *Validate* non-***networked*** claim sets. The outgoing contractor shall continue using the DCS to perform **all** DCS functions for claim sets associated with **financially underwritten** claims including researching *Open* claim sets, initiating new recoupments, entering refund data and linking adjustment data.		Continues researching and resolving potential duplicate claim sets.
First Day of The Fourth Month Following Services	Beginning on the first day of the fourth month following Services, refund checks received and offsets taken for recoupments associated with non-***networked*** duplicate claims payments and recoupment files associated with in progress non-***networked*** duplicate claim recoupments shall be processed and forwarded to the incoming contractor in accordance with the Financial Procedures in the Transition Plan, the contract, and the Operations Manual.	A "mass change" is initiated transferring all of the outgoing contractor's non-***networked*** DCS data to the incoming contractor's DCS.	Outgoing contractor's non-***networked*** DCS data appears on the incoming contractor's DCS. Incoming contractor begins performing DCS research, recoupment, and resolution functions on non-***networked*** potential duplicate claim sets transferred from the outgoing contractor as well as continuing to resolve their own duplicate claim sets.
Note: This schedule shall be incorporated into the transition plans for the outgoing contractor and the incoming contractor. Actual dates shall be established in the transition plans.			

DATES	OUTGOING CONTRACTOR	TMA	INCOMING CONTRACTOR
First Day of The Fourth Month Through The Last Day of HCSR Submissions For The Outgoing Contractor (as defined by the transition schedule)	The outgoing contractor shall continue using the DCS to perform **all** DCS functions for claim sets associated with **financially underwritten** claims including researching *Open* claim sets and initiating new recoupments. The outgoing contractor shall have moved 100% of all *Open* DCS claim sets to a *Pending*, *Validate*, or *Closed* status by the last day of HCSR submissions (as defined by the transition plan).	TMA prepares to have the outgoing contractor's passwords deleted from the DCS effective on the first day following the last day of HCSR submissions for the outgoing contractor (as defined by the transition schedule). TMA shall generate monthly reports showing the status of the outgoing contractor's network claim sets.	Continues to research and resolve potential duplicate claim sets appearing on the DCS. By the last day of the **sixth month following Services**, the incoming contractor shall have completed the required research and have moved a sufficient number of *Open* sets to a *Pending*, *Validate*, or *Closed* status to ensure compliance with DCS performance standards which become effective for the incoming contractor on first day of the seventh month following Services.
First Day of The Seventh Month Following Services		Generates DCS reports to verify that the incoming contractor is in compliance with performance standards.	The DCS performance standards shall be in effect (see Chapter 1, Section 3, paragraph 6.0. for the DCS performance standards).
Last Day of HCSR Submissions For The Outgoing Contractor (as defined by the transition schedule)	By the close of business, the outgoing contractor shall generate any DCS reports it wishes for its records.		Continues to research and resolve potential duplicate claim sets appearing on the DCS.
First Day Following The Last Day of HCSR Submissions For The Outgoing Contractor (as defined by the transition schedule)	Outgoing contractor can no longer access the DCS.	Outgoing contractor's DCS passwords are deleted. TMA generates DCS management reports showing the status of all DCS sets owned by the outgoing contractor. TMA will change the Responsible FI of all claims from the outgoing contractor to FI 99. *Open* claim sets owned by FI 99 are moved to a *Closed* status. *Pending* claim sets owned by FI 99 are moved to a *Validate* status.	Continues to research and resolve potential duplicate claim sets appearing on the DCS.
Note: This schedule shall be incorporated into the transition plans for the outgoing contractor and the incoming contractor. Actual dates shall be established in the transition plans.			

REPORT DESCRIPTIONS AND EXAMPLES

REPORT CATEGORY:	Set Report
REPORT MENU HIERARCHY AND FORMAT NAME:	REPORT ⇒SET REPORTS ⇒**BASIC**
PRINTED REPORT TITLE:	Duplicate Claim System Sets Grouped by Set Number
REPORT DESCRIPTION:	This report provides set-level information regarding all of the sets loaded in the Duplicate Claim System. The fields displayed on the report are: Institutional/Non-Institutional Indicator; Set Number; Status; Set Match Type; Multi-Contractor Set? (Y/N); Owner FI; Region; Initial Load Date; Current Load Date; Last Update Date; Adjustments? (Y/N); Total Amount Identified For Recoupment; Total Amount Actually Recouped; Total HCSR Adjustment Amount; and Set Level User Defined Code.
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 Set Level User Defined Codes.
REPORT NOTES:	The data used by this report format is set level data.

Status Code = All
Set User Codes = All
Adjust Type = All
Owner Type = All
Claim Type = Institutional
Match Type = All
Owner FI = 50
Owner Region = All
Set Number = All

Date: 8/24/2007

DUPLICATE CLAIM SYSTEM SETS
GROUPED BY SET NUMBER

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Area 1

INSTITUTIONAL

SET #	STATUS	MATCH TYPE	MULTI FI?	OWNER FI	REGION	INITIAL LOAD DATE	CURRENT LOAD DATE	LAST UPDATE DATE	ADJ?	ID RECOUP	ACTUAL RECOUP	ADJUSTMENT AMOUNT	SET USER CODE
6	O	D	N	50	50C0004	09/24/1996	12/16/1996	12/31/1996	N	$0.00	$0.00	$0.00	2C
15	O	N	N	50	50C0004	09/24/1996	09/24/1996	10/01/1996	Y	$0.00	$0.00	$0.00	
22	V	D	N	50	50C0004	09/24/1996	09/24/1996	06/11/2007	Y	$2,000.00	$1,115.44	$1,115.44	
3411	O	D	N	50	50C0004	09/24/1996	09/24/1996	10/23/1996	Y	$0.00	$0.00	$0.00	
7187	O	D	N	50	50C0004	09/24/1996	12/16/1996	12/16/1996	N	$0.00	$0.00	$0.00	
7240	O	N	Y	50	50C0004	09/24/1996	12/30/1996	02/12/1997	Y	$0.00	$0.00	$0.00	
19025	O	E	Y	50	50C0004	09/24/1996	12/16/1996	12/16/1996	Y	$0.00	$0.00	$0.00	
40803	O	D	N	50	50C0004	09/24/1996	10/24/1996	10/25/1996	Y	$0.00	$0.00	$0.00	
46549	O	D	Y	50	50C0004	09/24/1996	12/16/1996	12/16/1996	Y	$0.00	$0.00	$0.00	
66811	O	E	N	50	50C0004	09/24/1996	10/31/1996	11/01/1996	Y	$0.00	$0.00	$0.00	
							INSTITUTIONAL TOTAL			$2,000.00	$1,115.44	$1,115.44	
						Area 1 TOTAL				$2,000.00	$1,115.44	$1,115.44	
					50 - Acme Claims Processing TOTAL					$2,000.00	$1,115.44	$1,115.44	
				REPORT TOTAL						**$2,000.00**	**$1,115.44**	**$1,115.44**	

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REPORT CATEGORY:	Set Report
REPORT MENU HIERARCHY AND FORMAT NAME:	REPORT ⇒SET REPORTS ⇒**BASIC BY USER CODE**
PRINTED REPORT TITLE:	Duplicate Claim System Sets Grouped by User Code
REPORT DESCRIPTION:	This report provides set-level information regarding all of the sets loaded in the Duplicate Claim System grouped by Set Level User Defined Codes. The fields displayed on the report are: Institutional/Non-Institutional Indicator; Set Number; Status; Set Match Type; Multi-Contractor Set? (Y/N); Owner FI; Region; Initial Load Date; Current Load Date; Last Update Date; Adjustments? (Y/N); Total Amount Identified For Recoupment; Total Amount Actually Recouped; Total HCSR Adjustment Amount; and Set Level User Defined Code.
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 Set Level User Defined Codes.
REPORT NOTES:	The data used by this report format is set level data.

Status Code = All
Adjust Type = All
Owner Type = All
Claim Type = Institutional
Match Type = All
Owner FI = 50
Owner Region = All
Set Number = All
Set User Codes = All

Date: 8/24/2007

DUPLICATE CLAIM SYSTEM SETS GROUPED BY USER CODE

50 - Acme Claims Processing

Area 1

Blank User Code

INSTITUTIONAL

SET #	STAT	MATCH TYPE	MULTI FI?	OWNER FI	REGION	INITIAL LOAD DATE	CURRENT LOAD DATE	LAST UPDATE DATE	ADJ?	ID RECOUP	ACTUAL RECOUP	ADJUSTMENT AMOUNT	USER CODE
6	O	D	N	50	50C0004	09/24/1996	12/16/1996	12/31/1996	N	$0.00	$0.00	$0.00	2C
15	O	N	N	50	50C0004	09/24/1996	09/24/1996	10/01/1996	Y	$0.00	$0.00	$0.00	
22	V	D	N	50	50C0004	09/24/1996	09/24/1996	06/11/2007	Y	$2,000.00	$1,115.44	$1,115.44	
3411	O	D	N	50	50C0004	09/24/1996	09/24/1996	10/23/1996	Y	$0.00	$0.00	$0.00	
7187	O	D	N	50	50C0004	09/24/1996	12/16/1996	12/16/1996	N	$0.00	$0.00	$0.00	
7240	O	N	Y	50	50C0004	09/24/1996	12/30/1996	02/12/1997	Y	$0.00	$0.00	$0.00	
19025	O	E	Y	50	50C0004	09/24/1996	12/16/1996	12/16/1996	Y	$0.00	$0.00	$0.00	
40803	O	D	N	50	50C0004	09/24/1996	10/24/1996	10/25/1996	Y	$0.00	$0.00	$0.00	
46549	O	D	Y	50	50C0004	09/24/1996	12/16/1996	12/16/1996	Y	$0.00	$0.00	$0.00	
66811	O	E	N	50	50C0004	09/24/1996	10/31/1996	11/01/1996	Y	$0.00	$0.00	$0.00	

INSTITUTIONAL TOTAL	$2,000.00	$1,115.44	$1,115.44
Blank User Code TOTAL	$2,000.00	$1,115.44	$1,115.44
Area 1 TOTAL	$2,000.00	$1,115.44	$1,115.44
50 - Acme Claims Processing TOTAL	$2,000.00	$1,115.44	$1,115.44

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REPORT CATEGORY:	Set Report
REPORT MENU HIERARCHY AND FORMAT NAME:	REPORT ⇒SET REPORTS ⇒**USER LOG REPORT**
PRINTED REPORT TITLE:	User Log Grouped By Set Number (Transaction History)
REPORT DESCRIPTION:	This report identifies the users who made changes to a set and the dates on which the changes occurred. The fields displayed on the report are: Set Number; Status; Owner FI; Region; Initial Load Date; Current Load Date; Transaction Date; User ID; Total Amount Identified For Recoupment; Total Amount Actually Recouped; and Total HCSR Adjustment Amount. The report will identify all of the sets meeting the criteria selected on the report parameter screen and list all of the changes made to those sets along with the associated User Ids. The system detects changes to: the status of a set; the Owner FI; the Region; and the three total dollar amount fields. Whenever a change to one or more of these fields occurs, a "log" record is created and will appear on this report along with the User ID associated with the change(s). The report will not show log entries generated as a result of: sets to which claims have been added during the monthly load process; or sets that have been archived out of the active database to history. Users may see entries with an "System" or "CLAIMADD" as the User ID. These two User IDs are used by the DCS for set management purposes. These User Ids may appear when the system makes a change to a set. The report groups the data by Set Number in ascending order.
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 User IDs
REPORT NOTES:	The data used by this report format is set level data.

Status Code = All
Adjust Type = All
Owner Type = All
Claim Type = All
Match Type = All
1750 >= Set Number <= 1800
Owner FI = 50
Owner Region = All

Date: 9/13/02007

USER LOG GROUPED BY SET NUMBER (TRANSACTION HISTORY)

Set Number	Stat	Owner FI	Region	Initial Load Date	Current Load Date	Transaction Date	User Id	Total Amount Ident Recoup	Total Amount Actual Recoup	Total Allowed HCSR Adj
1765	O	45	Undetermined Region		04/14/1997	04/14/1997	CLAIMADD	$0.00	$0.00	$0.00
	O	03	Region 3, 4		04/14/1997	04/14/1997	SYSTEM	$0.00	$0.00	$0.00
	P	03	Region 3, 4		04/14/1997	02/22/1999	HMSPOOLE	$187.50	$0.00	$0.00
1770	O	13	Undetermined Region		04/14/1997	04/14/1997	CLAIMADD	$0.00	$0.00	$0.00
	P	13	Undetermined Region		04/14/1997	01/23/1998	UNICOLE	$143.20	$0.00	$0.00
	P	25	Region 2, 5		09/06/1998	09/06/1998	SYSTEM	$143.20	$0.00	$0.00
1776	O	57	Undetermined Region		04/14/1997	04/14/1997	CLAIMADD	$0.00	$0.00	$0.00
	O	06	Region 6		04/14/1997	04/14/1997	SYSTEM	$0.00	$0.00	$0.00
	P	06	Region 6		04/14/1997	06/30/1998	WPSWALS	$89.92	$0.00	$0.00
	P	06	Region 6		04/14/1997	04/01/1999	SYSTEM	$89.92	$0.00	$0.00
	P	06	Region 6		04/14/1997	04/14/1999	WPSWALS	$89.92	$50.92	$67.90
1778	O	53	Undetermined Region		04/14/1997	04/14/1997	CLAIMADD	$0.00	$0.00	$0.00
	O	99	Inactive - CA/HI 88C		04/14/1997	01/23/1998	SYSTEM	$0.00	$0.00	$0.00
	C	99	Inactive - CA/HI 88C	04/14/1997	04/14/1997	08/03/2004	REP	$0.00	$0.00	$0.00
1781	O	13	Undetermined Region		04/14/1997	04/14/1997	CLAIMADD	$0.00	$0.00	$0.00
	O	38	Undetermined Region		04/14/1997	01/23/1998	SYSTEM	$0.00	$0.00	$0.00
	P	38	Undetermined Region		04/14/1997	03/19/1998	PGBTHOMP	$54.40	$0.00	$0.00
	P	25	Region 2, 5		09/03/1998	09/03/1998	SYSTEM	$54.40	$0.00	$0.00
1789	O	13	Undetermined Region		04/14/1997	04/14/1997	CLAIMADD	$0.00	$0.00	$0.00
	P	13	Undetermined Region		04/14/1997	01/26/1998	UNICOLE	$188.50	$0.00	$0.00
	P	13	Undetermined Region		04/14/1997	03/31/1998	UNICOLE	$62.83	$0.00	$0.00
	P	25	Region 2, 5		09/06/1998	09/06/1998	SYSTEM	$62.83	$0.00	$0.00

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REPORT CATEGORY:	Set Report
REPORT MENU HIERARCHY AND FORMAT NAME:	REPORT ⇒SET REPORTS ⇒EXPLANATION REPORT ⇒ **NOTEPAD**
PRINTED REPORT TITLE:	Notepad
REPORT DESCRIPTION:	This report provides a listing of the notepad entries made on selected sets. The fields displayed on this report are: Set Number; Status; Match Type; Owner FI; Region; Initial Load Date; Current Load Date; and Notepad Entries.
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).
REPORT NOTES:	The data used by this report format is set level data.

Status Code = All
Adjust Type = All
Owner Type = All
Claim Type = All
Match Type = All
Owner FI = All
Owner Region = All
Set Number = All

Date: 8/24/2007

NOTEPAD

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Area 1

Set Number	Status	Match Type	Initial Load Date	Current Load Date
28	O	O	9/24/1996	1/24/1997

This is test #1 for notepad functionality.

Set Number	Status	Match Type	Initial Load Date	Current Load Date
73472	O	E	9/24/1996	1/24/1997

This is test #2 for notepad functionality.

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REPORT CATEGORY:	Set Report
REPORT MENU HIERARCHY AND FORMAT NAME:	REPORT ⇒SET REPORTS ⇒EXPLANATION REPORT ⇒ **VALIDATE**
PRINTED REPORT TITLE:	Validate Status Explanations
REPORT DESCRIPTION:	This report provides a listing of the explanations entered when sets are resolved to a *Validate* status. The Duplicate Claims System requires that an explanation be entered when a set is resolved to a *Validate* status. One of the required Validate explanations describes why the amount actually recouped and the allowed amount of the HCSR adjustments submitted do not equal the amount identified for recoupment. The other required Validate explanation describes why all of the line-items of a non-institutional actual duplicate claim have not been adjusted. The fields displayed on this report are: Set Number; Status; Match Type; Owner FI; Region; Initial Load Date; Current Load Date; and Validate Explanations.
REPORT PARAMETER OPTIONS:	Users may customize the report by selecting: All "Standard" parameters minus Claim Set Status (Adjustments, Set Owner Type, Claim Type, Match Type, Date Type, Set Range, FI, Region) plus the Solicited Indicator.
REPORT NOTES:	The data used by this report format is set level data.

Adjust Type = All
Owner Type = All
Claim Type = All
Match Type = All
Owner FI = All
Owner Region = All
Set Number = All

Date: 8/24/2007

VALIDATE STATUS EXPLANATIONS

50 - Acme Claims Processing

Area 1

Set Number	Status	Match Type	Initial Load Date	Current Load Date
22	V	D	9/24/1996	9/24/1996

Incorrect ID Recoup////

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REPORT CATEGORY:	Set Report
REPORT MENU HIERARCHY AND FORMAT NAME:	REPORT ⇒SET REPORTS ⇒EXPLANATION REPORT ⇒ **MODIFY**
PRINTED REPORT TITLE:	Modify FI Explanations
REPORT DESCRIPTION:	This report provides a listing of the explanations entered when the Owner FI is changed on multi-contractor sets. The Duplicate Claims System requires that an explanation be entered when ownership of a multi-contractor set is changed from one contractor to another. The explanation entered should indicate who changed set ownership, who the change was discussed with at the receiving contractor, the date the discussions and the change took place, and why ownership was changed. The fields displayed on the report are: Set Number; Status; Match Type; Owner FI; Region; Initial Load Date; Current Load Date; and the Modify FI Explanations.
REPORT PARAMETER OPTIONS:	Users may customize the report by selecting: All "Standard" parameters minus Owner Type (Claim Set Status; Adjustments, Claim Type, Match Type, Date Type, Set Range, FI, Region).
REPORT NOTES:	The data used by this report format is set level data.

Status Codes = ALL
Adjusted Type = Adjusted Only
Set Owner Type = ALL
Claim Type = Institutional
Duplicate Type = ALL
FI Code = 06
Region Code = ALL
Set Number Range=ALL

VALIDATE STATUS EXPLANATIONS

05/15/2006
Page 1

06 - Health Net Federal Services

Region 6

Set Number	Status	Match Type	Initial Load Date	Current Load Date
241017	V	N	05/01/2001	12/16/1996

"joe doe=8/22/01. remaining amount is a write-off //// money collected by aim collections"

Set Number	Status	Match Type	Initial Load Date	Current Load Date
266007	V	E	12/03/2001	12/03/2001

"Money received back in the amount of our allowed amount rather than the amount paid SaraE 032502"

Set Number	Status	Match Type	Initial Load Date	Current Load Date
303530	V	E	04/03/2002	04/03/2002

"Ruth Stoltz 04-01-2003 Credit received through AIM, no further credit."

Set Number	Status	Match Type	Initial Load Date	Current Load Date
303622	V	N	04/03/2002	04/03/2002

"Ruth Stoltz 08-22-2002 Payment recouped through AIM."

Set Number	Status	Match Type	Initial Load Date	Current Load Date
303664	V	N	04/03/2002	04/03/2002

"Ruth Stoltz 03-25-2003 Claim is recouped through AIM. No more credit will be applied to this account."

Set Number	Status	Match Type	Initial Load Date	Current Load Date
319708	V	E	05/09/2002	05/09/2002

"Ruth Stoltz 04-01-2003 Credit received through AIM, no further credit."

Set Number	Status	Match Type	Initial Load Date	Current Load Date
319743	V	N	05/09/2002	05/09/2002

"Ruth Stoltz 04-01-2003 Credit received through AIM, no further credit."

Set Number	Status	Match Type	Initial Load Date	Current Load Date
319764	V	N	05/09/2002	05/09/2002

"Ruth Stoltz 08-22-2002 Payment recouped through AIM."

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REPORT CATEGORY:	Set Report
REPORT MENU HIERARCHY AND FORMAT NAME:	REPORT ⇒SET REPORTS ⇒**REGION UNASSIGNED**
PRINTED REPORT TITLE:	Multi-Contractor Sets Region Missing
REPORT DESCRIPTION:	This report provides a listing of the multi-contractor sets in the Duplicate Claims System for which a region has not been assigned. All sets are assigned a region when they are loaded into the system and when mass changes occur. When ownership of a multi-contractor set is changed from one contractor to another, the receiving contract7or must assign the applicable region to the set. If the receiving contractor does not assign a region, the set cannot be associated with a particular contract. This report will provide receiving contractors with a listing of the sets which have not had regions assigned. The fields displayed on the report are: Set Number; Status; Initial Load Date; Current Load Date; and Owner FI.
REPORT PARAMETER OPTIONS:	Users may customize the report by selecting: All "Standard" parameters minus Owner Type and Set Range (Claim Set Status; Adjustments, Claim Type, Match Type, Date Type, FI, Region).
REPORT NOTES:	The data used by this report format is set level data.

Status Code = All
Adjust Type = Adjusted Only
Claim Type = Institutional
Match Type = All
Owner FI = 50
Owner Region = All
Set Number = All
Set User Codes = All

Date: 9/17/2007

MULTI-CONTRACTOR SETS REGION MISSING

11 - Health Net Federal Services

Set Number	Owner FI	Status	Initial Load Date	Current Load Date
703064	11	C	3/3/2003	7/28/2007
714986	11	O	3/3/2003	8/26/2004
858859	11	O	7/1/2003	8/27/2004
886816	11	O	8/4/2003	8/12/2004
920516	11	O	9/2/2003	8/17/2004
978552	11	P	12/1/2003	4/22/2004
991239	11	O	12/1/2003	9/21/2004
992497	11	P	12/1/2003	3/18/2004
1048862	11	P	2/2/2004	3/29/2004
1050346	11	O	2/2/2004	10/5/2004
1077959	11	P	3/1/2004	3/6/2004
1080157	11	P	3/1/2004	3/29/2004
1137686	11	P	5/3/2004	5/13/2004
1151465	11	P	5/3/2004	5/25/2004
1224955	11	O	8/2/2004	8/24/2004
1224961	11	O	8/2/2004	8/24/2004

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REPORT CATEGORY:	Set Report
REPORT MENU HIERARCHY AND FORMAT NAME:	REPORT ⇒SET REPORTS ⇒**SET COUNTS BY REGION**
PRINTED REPORT TITLE:	Set Counts By Region
REPORT DESCRIPTION:	This report provides the numbers of sets of each match type by contract region. The report shows the number of sets of each match type, the percentage each match type represents of the total number of sets for the region, the number of sets for each match type which have associated adjustments, and the percentage of each match type which have been adjusted. This report will show the distribution of sets for a region across match types. It will also show the user how many sets in a given match type category have associated adjustments and the percentage of that match type category which have adjustments. This report can serve as a tool for contractors to help diagnose causes for duplicate payments and to help determine workload and needed resources.
REPORT PARAMETER OPTIONS:	Users may customize the report by selecting: All "Standard" parameters minus Match Type and Set Range (Claim Set Status; Adjustments, Claim Type, Date Type, FI, Region) plus Set Level User Defined Codes.
REPORT NOTES:	The data used by this report format is set level data.

Status Code = All
Adjust Type = All
Owner Type = All
Claim Type = All
Owner FI = 50
Owner Region = All
Set User Codes = All

Date: 9/14/2007

SET COUNTS BY REGION

50 - Acme Claims Processing

Area 1

Match Type	# of Sets	% of Total	# of Adjusted Sets	% Adjusted
CPT-4	4	3.6%	4	100.0%
Date Overlap	25	22.3%	19	76.0%
Exact	35	31.3%	33	94.3%
Near	29	27.7%	21	72.4%
Other	17	15.2%	10	58.8%
Region Totals	**110**	**100.0 %**	**87**	**79.1%**
FI Totals	**110**	**100.0%**	**87**	**79.1%**

51 - Claims 'R' Us

Area 51

Match Type	# of Sets	% of Total	# of Adjusted Sets	% Adjusted
Near	1	100.0%	0	0.0%
Region Totals	**1**	**100.0%**	**0**	**0.0%**
FI Totals	**1**	**100.0%**	**0**	**0.0%**

99 - Inactive Contractor

Inactive - CA/HI 93C

Match Type	# of Sets	% of Total	# of Adjusted Sets	% Adjusted
Near	1	100.0%	0	0.0%
Region Totals	**1**	**100.0%**	**0**	**0.0%**

Inactive - CA/HI 88C

Match Type	# of Sets	% of Total	# of Adjusted Sets	% Adjusted
Near	1	100.0%	1	100.0%
Region Totals	**1**	**100.0%**	**1**	**100.0%**
FI Totals	**2**	**100.0%**	**1**	**50.0%**
Grand Totals	**114**	**100.0%**	**88**	**77.20%**

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REPORT CATEGORY:	Set Report
REPORT MENU HIERARCHY AND FORMAT NAME:	REPORT ⇒SET REPORTS ⇒**SET LEVEL USER CODES**
PRINTED REPORT TITLE:	Set Level User Defined Field Definitions
REPORT DESCRIPTION:	This report displays the Owner FI; the Set 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 set level data.

9/14/2007

SET LEVEL USER DEFINED FIELD DEFINITIONS

Owner FI	Contract #	Code	Description	Active ?
50	50C0004	86	testing 12	Y
50	50C0004	TT	TEST FI 50	Y

Owner FI	Contract #	Code	Description	Active ?
52	52C0005	45	TEST modify	Y

Owner FI	Contract #	Code	Description	Active ?
63	63D0004	2L	Test	Y
63	63D0004	88	testing	Y
63	63D0004	1A	Testy - 1A	Y
63	63D0004	2B	TEST - 2B	Y
63	63D0004	2E	Test	Y
63	63D0004	55	Tesyting	Y
63	63D0004	56	testing	Y
63	63D0004	44	testing	Y

Owner FI	Contract #	Code	Description	Active ?
73	73D0001	2G	TEST	Y
73	73D0006	2F	Tst	Y
73	73D0002	2G	TEST2g	N

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REPORT CATEGORY:	Claim Report
REPORT MENU HIERARCHY AND FORMAT NAME:	REPORT ⇒CLAIM REPORTS ⇒**BASIC**
PRINTED REPORT TITLE:	Basic Duplicate Claim Report Institutional and Non-Institutional Claim and Line Item Level Data
REPORT DESCRIPTION:	This report lists all of the claims loaded in the system grouped by claim number. The report will show institutional and non-institutional claims. This report format will allow the user to select by Duplicate Flag values. The fields displayed on the report are: Owner FI; ICN; HCSR Suffix; Claim Level User Defined Code; Solicited Indicator; Set Number; Duplicate Flag Value; Reason Code; Processed-To-Completion Date; Responsible FI Number; Sponsor Social Security Number; Patient Name; DEERS Dependent Suffix; Provider Tax ID; Provider Sub-ID; Amount Billed; Amount Allowed; Amount Identified For Recoupment; Amount Actually Recouped. For non-institutional claims, line item data will also be displayed. The line item fields displayed include: Line Item Number; Line Item Match Type; Procedure Code; Place of Service; Type of Service; Care Begin Date; Care End Date; Line Item Amount Billed for the Procedure; and Amount Allowed for the Procedure. The report identifies and prints all of the claims occurring in sets meeting the criteria selected on the report parameter screen.
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 Dupe Flag Indicator; Solicited Indicator; Exclude Base; PTC Date; Set Level User Defined Codes; Claim Level User Defined Codes; Responsible FI and Region.
REPORT NOTES:	The data used by this report format is claim level and line item level data. If a non-institutional claim exists in more than one set, it will print for each set in which it exists. Each instance of these non-institutional claims existing in multiple sets will contain a different set number on the report.

Status Code = All
Adjust Type = All
Owner Type = All
Claim Type = All
Match Type = All
Owner FI = 50
Owner Region = All
Resp FI = All
Resp Region = All
Dupe Flag = All
250 >= Set Number <= 350
Set User Codes = All
Exclude Base Claims = No
Solicited = All
Claim User Codes = All
Enroll Codes = All

Date: 9/14/2007

BASIC DUPLICATE CLAIM SYSTEM REPORT
INSTITUTIONAL AND NON-INSTITUTIONAL
CLAIM & LINE ITEM LEVEL DATA

50 - Acme Claims Processing

ICN	SFX	USR CD	S ?	SET #	DUP FLG	RSN CODE	PTC DATE	RESP FI	SPON SSAN	PATIENT NAME	DDS	PROVIDER TAX ID	PROV SUB-ID	AMT BILLED	AMT ALLOWED	AMT ID RECOUP	AMT ACTUAL RECOUP
19940462508505	A			251	N	BASE	3/10/1994	50	999999999	SMITH, JANE, X	20	555555555	0000	$2,175.00	$1,244.50	$0.00	$0.00
				LI#	M Type		CPT-4	POS	TOS	Care Begin	Care End	Amt Billed CPT-4		Amt Allowed CPT-4			
				4	C		99221	21	11	7/20/1992	7/20/1992		$150.00		$90.70		
19940462508505	A			252	N	BASE	3/10/1994	50	999999999	SMITH, JANE, X	20	555555555	0000	$2,175.00	$1,244.50	$0.00	$0.00
				LI#	M Type		CPT-4	POS	TOS	Care Begin	Care End	Amt Billed CPT-4		Amt Allowed CPT-4			
				3	E		99232	21	11	7/21/1992	7/24/1992		$450.00		$385.20		
19942022508010	A			254			8/04/1994	50	999999999	SMITH, JANE, X	20	555555555	0000	$2,175.00	$1,255.90	$0.00	$0.00
				LI#	M Type		CPT-4	POS	TOS	Care Begin	Care End	Amt Billed CPT-4		Amt Allowed CPT-4			
				2	N		45378	21	I2	7/27/1992	7/27/1992		$1000.00		$406.20		
19942273733672	A			268			10/21/1994	50	999999999	SMITH, JANE, X	04	555555555	A001	$1,073.13	$705.35	$0.00	$0.00
				LI#	M Type		CPT-4	POS	TOS	Care Begin	Care End	Amt Billed CPT-4		Amt Allowed CPT-4			
				2	N		93307	11	O1	11/12/1993	11/12/1993		$206.00		$204.10		
				3	O		93325	11	O1	11/12/1993	11/12/1993		$85.00		$85.00		
				4	O		71010	11	O4	11/12/1993	11/12/1993		$42.00		$24.80		
				5	O		73120	11	O4	11/12/1993	11/12/1993		$33.00		$32.30		

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REPORT CATEGORY:	Claim Report
REPORT MENU HIERARCHY AND FORMAT NAME:	REPORT ⇒CLAIM REPORTS ⇒**BASIC BY SET**
PRINTED REPORT TITLE:	Basic Duplicate Claim Report By Set Institutional and Non-Institutional Claim and Line Item Level Data
REPORT DESCRIPTION:	This report lists all of the claims loaded in the system grouped by set number. The report will show institutional and non-institutional claims. This report format will allow the user to select by Duplicate Flag values. The fields displayed on the report are: Owner FI; ICN; HCSR Suffix; Claim Level User Defined Code; Solicited Indicator; Set Number; Duplicate Flag Value; Reason Code; Processed-To-Completion Date; Responsible FI Number; Sponsor Social Security Number; Patient Name; DEERS Dependent Suffix; Provider Tax ID; Provider Sub-ID; Amount Billed; Amount Allowed; Amount Identified For Recoupment; Amount Actually Recouped. For non-institutional claims, line item data will also be displayed. The line item fields displayed include: Line Item Number; Line Item Match Type; Procedure Code; Place of Service; Type of Service; Care Begin Date; Care End Date; Line Item Amount Billed for the Procedure; and Amount Allowed for the Procedure. The report identifies and prints all of the claims occurring in sets meeting the criteria selected on the report parameter screen.
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 Dupe Flag Indicator; Solicited Indicator; Exclude Base; PTC Date; Set Level User Defined Codes; Claim Level User Defined Codes; Responsible FI and Region.
REPORT NOTES:	The data used by this report format is claim level and line item level data. If a non-institutional claim exists in more than one set, it will print for each set in which it exists. Each instance of these non-institutional claims existing in multiple sets will contain a different set number on the report.

Status Code = All
Adjust Type = All
Owner Type = All
Claim Type = All
Match Type = All
Owner FI = 50
Owner Region = All
Resp FI = All
Resp Region = All
Dupe Flag = All
250 >= Set Number <= 350
Set User Codes = All
Exclude Base Claims = No
Solicited = All
Claim User Codes = All
Enroll Codes = All

Date: 9/14/2007

BASIC DUPLICATE CLAIM REPORT BY SET
INSTITUTIONAL AND NON-INSTITUTIONAL
CLAIM & LINE ITEM LEVEL DATA

50 - Acme Claims Processing

SET#	ICN	SFX	USR CD	S?	DUP FLG	RSN CODE	PTC DATE	RESP FI	SPON SSAN	PATIENT NAME	DDS	PROVIDER TAX ID	PROV SUB-ID	AMT BILLED	AMT ALLOWED	AMT ID RECOUP	AMT ACTUAL RECOUP
251	19940462508505	A			N	BASE	03/10/1994	50	999999999	SMITH, JANE, X	20	555555555	0000	$2,175.00	$1,244.50	$0.00	$0.00
			LI#		M Type		CPT-4	POS	TOS	Care Begin		Care End	Amt. Billed CPT-4		Amt. Allowed CPT-4		
			4		C		99221	21	I1	07/20/1992		07/20/1992	$150.00		$90.70		
252	19940462508505	A			N	BASE	03/10/1994	50	999999999	SMITH, JANE, X	20	555555555	0000	$2,175.00	$1,244.50	$0.00	$0.00
			LI#		M Type		CPT-4	POS	TOS	Care Begin		Care End	Amt. Billed CPT-4		Amt. Allowed CPT-4		
			3		E		99232	21	I1	07/21/1992		07/24/1992	$450.00		$385.20		
254	19942022508010	A					08/04/1994	50	999999999	SMITH, JANE, X	20	555555555	0000	$2,175.00	$1,244.50	$0.00	$0.00
			LI#		M Type		CPT-4	POS	TOS	Care Begin		Care End	Amt. Billed CPT-4		Amt. Allowed CPT-4		
			2		N		45378	21	I1	07/27/1992		07/27/1992	$1000.00		$406.20.20		
268	19442273733672	A					10/21/1994	50	999999999	SMITH, JANE, X	04	555555555	A001	$1,073.13	$705.35	$0.00	$0.00
			LI#		M Type		CPT-4	POS	TOS	Care Begin		Care End	Amt. Billed CPT-4		Amt. Allowed CPT-4		
			2		N		93307	11	O1	11/12/1993		11/12/1993	$206.00		$204.10		
			3		O		93325	11	O1	11/12/1993		11/12/1993	$85.00		$85.00		
			4		O		71010	11	O4	11/12/1993		11/12/1993	$42.00		$24.80		
			5		O		73120	11	O4	11/12/1993		11/12/1993	$33.00		$32.30		

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REPORT CATEGORY:	Claim Report
REPORT MENU HIERARCHY AND FORMAT NAME:	REPORT ⇒CLAIM REPORTS ⇒**INSTITUTIONAL**
PRINTED REPORT TITLE:	Institutional Claims
REPORT DESCRIPTION:	This report lists institutional claims grouped by current set status. This report lists institutional claims within their respective sets. The fields displayed on the report are: Owner FI; Institutional Indicator; Status Code; Set Number; ICN; HCSR Suffix (S); Claim Level User Defined Code; Solicited Indicator; Dupe Flag Indicator; Processed to Completion Date; Responsible FI Number; Sponsor Social Security Number; Patient Name; DEERS Dependent Suffix; Date of Birth; Provider Tax ID; Provider Sub-ID; Amount Billed; Amount Allowed; and Net Government Paid 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 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 claim level data. The billed, allowed and net Government paid amounts are claim level dollar amounts.

Status Code = All
Adjust Type = All
Owner Type = All
Match Type = E,
Owner FI = 50
Owner Region = All
Resp FI = All
Resp Region = All
Dupe Flag = All
Set Number = All
Set User Codes = All
Exclude Base Claims = No
Solicited = All
Claim User Codes = All
Enroll Codes = All

Date: 9/14/2007

INSTITUTIONAL CLAIMS

50 - Acme Claims Processing

INSTITUTIONAL
STATUS CODE : O

SET #	ICN	SFX	USR CD	S ?	DUP FLG	RSN CODE	PTC DATE	RS FI	SPON SSAN	PATIENT NAME	DDS	DOB	PROVIDER TAX ID	PROV SUB-ID	AMT BILLED	AMT ALLOWED	NET GOVT PAID AMT
7207	19942832105001	A			N	BASE	10/13/1994	50	999999999	SMITH, JANE, X	01	4/30/1987	555555555	0005	$3,009.03	$1,935.02	$1,226.37
7207	19943082108001	A					11/14/1994	50	999999999	SMITH, JANE, X	01	4/30/1987	555555555	0005	$3,009.03	$1,935.02	$1,226.37
26697	19951374876332	A			N	BASE	5/31/1995	50	999999999	SMITH, JANE, X	20	7/06/1932	555555555	0000	$14,851.75	$6,156.84	$4,332.84
26697	19951374876332	B					7/18/1995	50	999999999	SMITH, JANE, X	20	7/06/1932	555555555	0000	$14,851.75	$6,156.84	$4,332.84
26697	19952504804675	A					9/14/1995	50	999999999	SMITH, JANE, X	20	7/06/1932	555555555	0000	$14,580.75	$6,156.84	$4,332.84
74409	19962565171004	A			N	BASE	9/24/1996	50	999999999	SMITH, JANE, X	31	9/23/1957	555555555	0000	$2,056.26	$1,045.74	$522.87
74409	19962565171004	A					9/24/1996	50	999999999	SMITH, JANE, X	31	9/23/1957	555555555	0000	$2,056.26	$1,045.74	$1,045.74
															$54,414.83		$17,019.87
													Status Totals			$23,397.49	
													Contractor Totals		$54,414.83		$17,019.87
																$23,397.49	
													Grand Totals		$54,414.83		$17,019.87
																$23,397.49	

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REPORT CATEGORY:	Claim Report
REPORT MENU HIERARCHY AND FORMAT NAME:	REPORT ⇒CLAIM REPORTS ⇒NON-INSTITUTIONAL ⇒**BY CLAIM**
PRINTED REPORT TITLE:	Non-Institutional Claims
REPORT DESCRIPTION:	This report lists non-institutional claims grouped by current set status. This report lists non- institutional claims within their respective sets. 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; Dupe Flag Indicator; Processed to Completion Date; Responsible FI; Sponsor Social Security Number; Patient Name; DEERS Dependent Suffix; Date of Birth; Provider Tax ID; Provider Sub-ID; Amount Billed; Amount Allowed; and Net Government Paid 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 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, Processed To Completion 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 claim level data. The billed, allowed and net Government paid amounts are claim level not line-item level dollar amounts.

Status Code = All
Adjust Type = All
Owner Type = All
Exclude Base Claims = No
Match Type = E,
Dupe Flag = All
Solicited = All
Set Number = All
Owner FI = 50
Owner Region = All
Resp FI = All
Resp Region = All
Set User Codes = All
Claim User Codes = All
Enroll Codes = All

Date: 9/14/2007

NON-INSTITUTIONAL CLAIMS

50 - Acme Claims Processing

Area 1

STATUS CODE : C

ICN	SFX	USR CD	S ?	DUP FLG	SET#	PTC DATE	RESP FI	SPON SSAN	PATIENT NAME	DDS	DOB	PROVIDER TAX ID	PROV SUB-ID	AMT BILLED	AMT ALLOWED	NET GOVT PAID AMT
19941925400374	A			N	123	7/25/1994	50	999999999	SMITH, JANE X	30	9/28/1899	555555555	0000	$455.00	$307.10	$230.32
19942065400200	A				123	8/10/1994	99	999999999	SMITH, JANE X	30	9/28/1899	555555555	0000	$455.00	$307.10	$230.32
												Status Totals		$910.00	$614.20	$460.64

STATUS CODE : O

ICN	SFX	USR CD	S ?	DUP FLG	SET#	PTC DATE	RESP FI	SPON SSAN	PATIENT NAME	DDS	DOB	PROVIDER TAX ID	PROV SUB-ID	AMT BILLED	AMT ALLOWED	NET GOVT PAID AMT
19950031241906	D			N	20000	1/12/1995	50	999999999	SMITH, JANE X	20	2/16/1930	555555555	A212	$572.00	$54.71	$41.03
19950031241906	F				20000	4/03/1995	50	999999999	SMITH, JANE X	20	2/16/1930	555555555	A212	$197.00	$86.19	$64.64
												Status Totals		$769.00	$140.90	$105.67
												Region Totals		$1,679.00	$755.10	$566.31
												Contractor Totals		$1,679.00	$755.10	$566.31
												Grand Total		**$1,679.00**	**$755.10**	**$566.31**

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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.

Status Code = All
Adjust Type = All
Owner Type = All
Exclude Base Claims = No
Match Type = All
Dupe Flag = All
Solicited = All
Set Number = All
Owner FI = 51
Owner Region = All
Resp FI = All
Resp Region = All
Set User Codes = All
Claim User Codes = All
Enroll Codes = All

Date: 9/14/2007

NON-INSTITUTIONAL CLAIMS BY LINE ITEM

51 - Claims 'R' Us

Area 51

STATUS CODE : O

ICN	SFX	USR CD	S ?	SET #	RESP FI	SPON SSAN	PATIENT NAME	DDS	PROVIDER TAX ID	PROV SUB-ID	LI	CPT-4 CODE	CARE BEGIN	CARE END	AMT ALLOWED CPT-4 CODE
19952861212951	A			41049	51	999999999	SMITH,LESLIE,X	30	555555555	0000	1	88235	8/18/1995	8/18/1995	$169.05
19952861212951	A			41049	51	999999999	SMITH,LESLIE,X	30	555555555	0000	2	88267	8/18/1995	8/18/1995	$459.00
19952861212951	A			41049	51	999999999	SMITH,LESLIE,X	30	555555555	0000	3	88280	8/18/1995	8/18/1995	$42.50
19952861212951	A			41049	51	999999999	SMITH,LESLIE,X	30	555555555	0000	4	82106	8/18/1995	8/18/1995	$28.70
19952890404473	A			41049	73	999999999	SMITH,LESLIE,X	30	555555555	0000	1	82106	8/18/1995	8/18/1995	$45.00
19952994209053	A			41049	50	999999999	SMITH,LESLIE,X	30	555555555	0000	1	88235	8/18/1995	8/18/1995	$169.05
19952994209053	B			41049	50	999999999	SMITH,LESLIE,X	30	555555555	0000	1	88267	8/18/1995	8/18/1995	$507.15
19952994209053	B			41049	50	999999999	SMITH,LESLIE,X	30	555555555	0000	2	88280	8/18/1995	8/18/1995	$76.50
														Status Totals	$1,496.95
														Regions Totals	$1,496.95
														Contractor Totals	$1,496.95
														Grand Total	$1,496.95

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REPORT CATEGORY:	Claim Report
REPORT MENU HIERARCHY AND FORMAT NAME:	REPORT ⇒CLAIM REPORTS ⇒RISK ⇒**RISK BASIC**
PRINTED REPORT TITLE:	Risk Report By ICN
REPORT DESCRIPTION:	This report provides a listing of claims based on the Risk Indicator values selected by the user. The Risk Indicator identifies the claim as either Financially Underwritten or Non-Financially Underwritten. The claims are grouped by claim number. The report can show both institutional and 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; Duplicate Flag Value; Risk Indicator; Responsible FI; Sponsor Social Security Account Number; Patient Name; DEERS Dependent Suffix; Provider Tax ID; Provider Sub-ID; Amount Billed; Amount Allowed; Government Paid Amount; Amount Identified For Recoupment; Amount Actually Recouped; Adjustment Amount.
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 Dupe Flag Indicator, Solicited Indicator, Exclude Base, PTC Dates, Care Dates, Set Level User Defined Codes, Claim Level User Defined Codes, Responsible FI, Region, and Risk Indicator.
REPORT NOTES:	The data used by this report format is claim level data. For non-institutional claims, the billed, allowed and net Government paid amounts are claim level not line-item level dollar amounts.

Status Code = All
Enroll Codes = All
Owner Type = All
Claim Type = All
Adjust Type = All
Match Type = All
Exclude Base Claims = No
Owner FI = All
Owner Region = All
Resp Region = All
Resp FI = All
100 >= Set Number <= 300
Set User Codes = All
Claim User Codes = All
Solicited = All
Dupe Flag = All
Risk Ind = All

Date: 9/14/2007

RISK REPORT BY ICN

99 - Acme Claims Processing

Area 1

ICN	SFX	USR CD	S?	SET#	DUP FLG	COV IND	RISK IND	RESP FI	SPON SSAN	PATIENT NAME	DDS	PROVIDER TAX ID	PROV SUB-ID	AMT BILLED	AMT ALLOWED	GOV PAID	ID RECOUP	ACTUAL RECOUP	ADJ AMOUNT
19931725370509	A			104	N	F	N	50	999999999	SMITH, JANE	31	555555555	0000	$3,604.00	$2,645.96	$2,618.06	$0.00	$0.00	$0.00
19931725370509	B			104		F	N	50	999999999	SMITH, JANE	31	555555555	0000	$3,604.00	$2,253.18	$2,225.28	$0.00	$0.00	$0.00
19941925400374	A			121	N	D	N	50	999999999	SMITH, JANE	30	555555555	0000	$455.00	$307.10	$230.32	$0.00	$0.00	$0.00
19941925400374	A			122	N	D	N	50	999999999	SMITH, JANE	30	555555555	0000	$455.00	$307.10	$230.32	$0.00	$0.00	$0.00
19941925400374	A			123	N	D	N	50	999999999	SMITH, JANE	30	555555555	0000	$455.00	$307.10	$230.32	$0.00	$0.00	$0.00
19942065400200	A			121		F	N	50	999999999	SMITH, JANE	30	555555555	0000	$455.00	$307.10	$230.32	$0.00	$0.00	$0.00
19942065400200	A			122		F	N	50	999999999	SMITH, JANE	30	555555555	0000	$455.00	$307.10	$230.32	$0.00	$0.00	$0.00
19942065400200	A			123		F	N	50	999999999	SMITH, JANE	30	555555555	0000	$455.00	$307.10	$230.32	$0.00	$0.00	$0.00
										Region Total				$9,938.00	$6,741.74	$6,225.26	$0.00	$0.00	$0.00
										Contractor Total				$9,938.00	$6,741.74	$6,225.26	$0.00	$0.00	$0.00
										Report Total				$9,938.00	$6,741.74	$6,225.26	$0.00	$0.00	$0.00

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REPORT CATEGORY:	Claim Report
REPORT MENU HIERARCHY AND FORMAT NAME:	REPORT ⇒CLAIM REPORTS ⇒RISK ⇒**RISK BY SET**
PRINTED REPORT TITLE:	Risk Report By Set Number
REPORT DESCRIPTION:	This report provides a listing of claims based on the Risk Indicator values selected by the user. The Risk Indicator identifies the claim as either Financially Underwritten or Non-Financially Underwritten. The claims are grouped by set number. The report can show both institutional and non- institutional claims. The fields displayed on the report are: Owner FI; Region; Set Number; ICN; HCSR Suffix; Claim Level User Defined Code; Solicited Indicator; Duplicate Flag Value; Risk Indicator; Responsible FI; Sponsor Social Security Account Number; Patient Name; DEERS Dependent Suffix; Provider Tax ID; Provider Sub-ID; Amount Billed; Amount Allowed; Government Paid Amount; Amount Identified For Recoupment; Amount Actually Recouped; Adjustment Amount.
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 Dupe Flag Indicator, Solicited Indicator, Exclude Base, PTC Dates, Care Dates, Set Level User Defined Codes, Claim Level User Defined Codes, Responsible FI, Region, and Risk Indicator.
REPORT NOTES:	The data used by this report format is claim level data. For non-institutional claims, the billed, allowed and net Government paid amounts are claim level not line-item level dollar amounts.

Status Code = All
Adjust Type = All
Owner Type = All
Exclude Base Claims = No
Claim Type = All
Match Type = All
Dupe Flag = All
100 >= Set Number <= 500
Owner FI = All
Owner Region = All
Resp FI = All
Resp Region = All
Set User Codes = All
Claim User Codes = All
Risk Ind = All
Solicited = All
Enroll Codes = All

Date: 9/14/2007

RISK REPORT BY SET NUMBER

50 - Acme Claims Processing

Area 1

SET#	ICN	SFX	USR CD	S ?	DUP FLG	COV IND	RISK IND	RESP FI	SPON SSAN	PATIENT NAME	DDS	PROVIDER TAX ID	PROV SUB-ID	AMT BILLED	AMT ALLOWED	GOV PAID	ID RECOUP	ACTUAL RECOUP	ADJ AMOUNT
104	19931725370509	A			N	F	N	50	999999999	SMITH, JANE	31	555555555	0000	$3,604.00	$2,645.96	$2,618.06	$0.00	$0.00	$0.00
104	19931725370509	B				F	N	50	999999999	SMITH, JANE	31	555555555	0000	$3,604.00	$2,253.18	$2,225.28	$0.00	$0.00	$0.00
										Region Totals				$7,208.00		$4,843.34		$0.00	
															$4,899.14		$0.00		$0.00
										Contractor Totals				$7,208.00		$4,843.34		$0.00	
															$4,899.14		$0.00		$0.00

55 - East West Claims

Undetermined Region

SET#	ICN	SFX	USR CD	S ?	DUP FLG	COV IND	RISK IND	RESP FI	SPON SSAN	PATIENT NAME	DDS	PROVIDER TAX ID	PROV SUB-ID	AMT BILLED	AMT ALLOWED	GOV PAID	ID RECOUP	ACTUAL RECOUP	ADJ AMOUNT
371	19941585303498	A				F	N	50	999999999	SMITH, JANE	30	555555555	A001	$55.00	$32.82	$24.62	$0.00	$0.00	$0.00
										Region Totals				$55.00		$24.62		$0.00	
															$32.82		$0.00		$0.00
										Contractor Totals				$55.00		$24.62		$0.00	
															$32.82		$0.00		$0.00
										Grand Totals				$7,263.00		$4,867.96		$0.00	
															$4,931.96		$0.00		$0.00

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REPORT CATEGORY:	Claim Report
REPORT MENU HIERARCHY AND FORMAT NAME:	REPORT ⇒CLAIM REPORTS ⇒RISK ⇒**RISK SUMMARY**
PRINTED REPORT TITLE:	Risk Summary Report
REPORT DESCRIPTION:	This report summarizes by Region the amounts billed, allowed and Government paid amounts, as well as the amounts identified for recoupment, amounts actually recouped, and adjustment amounts. The fields displayed on the report are: Region; Amount Billed; Amount Allowed; Government Paid Amount; Amount Identified for Recoupment; Amount Actually Recouped; and Adjustment Amount.
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 Dupe Flag Indicator, Solicited Indicator, Exclude Base, PTC Dates, Care Dates, Set Level User Defined Codes, Claim Level User Defined Codes, Responsible FI, Region, and Risk Indicator.
REPORT NOTES:	The data used by this report format is claim level data. For non-institutional claims, the billed, allowed and net Government paid amounts are claim level not line-item level dollar amounts.

Status Code = All
Adjust Type = All
Owner Type = All
Exclude Base Claims = No
Claim Type = All
Match Type = All
Dupe Flag = All
Set Number = All
Owner FI = All
Owner Region = All
Resp FI = All
Resp Region = All
Risk Ind = All
Solicited = All
Set User Codes = All
Claim User Codes = All
Enroll Codes = All

Date: 9/14/2007

RISK SUMMARY REPORT

	50 - Acme Claims Processing					
	Amt Billed	Amt Allowed	Gov Paid	ID Recoup	Actual Recoup	Adj Amount
Area 1	$1,652,372.16	$1,065,849.99	$928,759.46	$2,000.00	$1,115.44	$1,115.44
Contractor Totals	$1,652,372.16	$1,065,849.99	$928,759.46	$2,000.00	$1,115.44	$1,115.44
Grand Totals	$1,652,372.16	$1,065,849.99	$928,759.46	$2,000.00	$1,115.44	$1,115.44

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Page 1

REPORT CATEGORY:	Claim Report
REPORT MENU HIERARCHY AND FORMAT NAME:	REPORT ⇒CLAIM REPORTS ⇒PROVIDER ⇒**CLAIM COUNTS**
PRINTED REPORT TITLE:	Provider Claim Count Report Grouped By Provider Number and Sub-ID
REPORT DESCRIPTION:	This report provides a total count by Provider Tax ID and Provider Sub-ID of all claims associated with selected providers. The fields displayed are: Provider Tax ID; Provider Sub-ID; and Total Number of Claims.
REPORT PARAMETER OPTIONS:	Users may customize the report by selecting: All "Standard" parameters minus Last (update) Date, Set Range (Claim Set Status; Adjustments, Set Owner Type; Claim Type, Match Type, Date Type, FI, Region) plus Dupe Flag Indicator, PTC Dates, Responsible FI, Region, and Provider Tax IDs.
REPORT NOTES:	The data used by this report format is claim level data.

Status Code = All
Adjust Type = All
Owner Type = All
Claim Type = All
Match Type = All
Dupe Flag = All
Owner FI = All
Owner Region = All
Resp FI = All
Resp Region = All
Provider Tax Codes = All
Enroll Codes = All

Date: 9/14/2007

PROVIDER CLAIM COUNT REPORT
GROUPED BY PROVIDER NUMBER AND SUB ID

Tax ID : 555555555		# Claims
Sub ID : 0000		
	Sub Id Totals	171
Sub ID : 0001		
	Sub Id Totals	23
Sub ID : 0002		
	Sub Id Totals	9
Sub ID : 0003		
	Sub Id Totals	4
Sub ID : 0004		
	Sub Id Totals	2
Sub ID : 0005		
	Sub Id Totals	2
Sub ID : 0008		
	Sub Id Totals	2
Sub ID : A001		
	Sub Id Totals	18
Sub ID : A002		
	Sub Id Totals	6
Sub ID : A003		
	Sub Id Totals	8
Sub ID : A004		
	Sub Id Totals	2
Sub ID : A006		
	Sub Id Totals	3
Sub ID : A009		
	Sub Id Totals	2
	Tax Id Totals	252

Tax ID : 751680173		# Claims
Sub ID : A015		
	Sub Id Totals	2
	Tax Id Totals	2

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REPORT CATEGORY:	Claim Report
REPORT MENU HIERARCHY AND FORMAT NAME:	REPORT ⇒CLAIM REPORTS ⇒PROVIDER ⇒**CLAIM DETAIL**
PRINTED REPORT TITLE:	Provider Claim Detail Report Grouped By Provider Number And Sub-ID
REPORT DESCRIPTION:	This report provides a listing of claims grouped by Provider Tax ID and Sub-ID, associated with selected providers. The fields displayed are: Provider Tax ID; Provider Sub-ID; ICN; HCSR Time Stamp; HCSR Suffix; Claim Level User Defined Code; Solicited Indicator; Set #; Duplicate Flag Indicator; Sponsor SSAN; Patient Name; DEERS Dependent Suffix; Amount Allowed; PTC Date; Responsible FI; Total number of claims and total Allowed Amounts by Provider Sub-ID; and Total number of claims and total Allowed Amounts by Provider Tax-ID.
REPORT PARAMETER OPTIONS:	Users may customize the report by selecting: All "Standard" parameters minus Last (update) Dates, Set Range (Owner Type, Claim Set Status; Adjustments, Claim Type, Match Type, Date Type, Set Range, FI, Region) plus Dupe Flag Indicator, Solicited Indicator, PTC Dates, Responsible FI, Region, Set Level User Defined Codes, Claim Level User Defined Codes, and Provider Tax IDs.
REPORT NOTES:	The data used by this report format is claim level data.

Status Code = All
Adjust Type = All
Claim Type = All
Owner Type = All
Match Type = All
Dupe Flag = All
Owner FI = All
Owner Region = All
Resp FI = All
Resp Region = All
Provider Tax Codes = All
Solicited = All
Set User Codes = All
Claim User Codes = All
Enroll Codes = All

Date: 9/14/2007

PROVIDR CLAIM DETAIL REPORT
GROUPED BY PROVIDER NUMBER AND SUB ID

ICN	TIME	SFX	USER CODE	S ?	SET#	DUP FLG	SPON SSAN	PATIENT NAME	DDS	AMT ALLOWED	PTC DATE	RESP FI
Tax ID: 555555555												
Sub ID: 0000												
19952861212951	271100	A			41049		999999999	SMITH,JANE	30	$699.25	11/06/1995	51
19952890404473	115546	A			41049	N	999999999	SMITH,JANE	30	$45.00	10/24/1995	73
19952994209053	340242	A			41049		999999999	SMITH,JANE	30	$169.05	12/19/1995	50
19952994209053	340242	B			41049		999999999	SMITH,JANE	30	$583.65	12/19/1995	50
								#Claims		Allowed $		
						Sub ID Totals		4		$1,496.95		
						Tax ID Totals		4		$1,496.95		

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REPORT CATEGORY:	Claim Report
REPORT MENU HIERARCHY AND FORMAT NAME:	REPORT ⇒CLAIM REPORTS ⇒PROVIDER ⇒**CPT-4**
PRINTED REPORT TITLE:	Provider CPT-4 Report Grouped By Provider Tax-ID and Sub-ID (CPT-4 Claim Level Match Types Only)
REPORT DESCRIPTION:	This report shows line items which appear on non-institutional **claims** which carry a CPT-4 match type ('C') at the claim level (see REPORT NOTES below). Due to the way the Duplicate Claims System assigns match types to claims and sets, this report must be used very carefully. Users have the option in this report of selecting actual duplicate claims only. The user may think that the report is showing only actual duplicate line items identified by the CPT-4 match type criteria. In fact, the report is showing the line-items of actual ('Y') non-institutional duplicate claims which have been assigned a match type of CPT-4 (see REPORT NOTES below). As a result, line items identified using the OTHER match type may appear on this report along with the line items identified under the CPT-4 criteria which caused the claim to be assigned the match type of CPT-4. This report will not show any line items identified under the EXACT or NEAR match criteria since line items identified using the EXACT and NEAR match would force the claim(s) to be assigned a higher level match type than CPT- 4. This report looks for only those actual duplicate non-institutional **claims** with a match type of CPT- 4 and then lists the line items on those claims. This report can be used by Program Integrity staff to obtain a listing of the claims carrying a match type of CPT-4 and their associated line items. Using the Provider Claim Count Report, users can identify the provider numbers associated with high volumes of non-institutional claims involving line items whose last two digits of the procedure code have been changed. Then using the Provider CPT-4 Report and entering those provider numbers identified, the user can generate a listing of the non-institutional claims with line item details associated with those provider numbers. The fields displayed on this report are: ICN; HCSR Timestamp; HCSR Suffix; Claim Level User Defined Code; Solicited Indicator; Set #; Duplicate Flag Indicator; Sponsor SSAN; Patient Name; DEERS Dependent Suffix; Line Item Match Type; Line Item Number; CPT-4 Code; Amount Allowed CPT-4; PTC Date; and Responsible FI. The report is grouped by Provider Number and Sub-ID and provides sub-totals for each provider Sub-ID and grand totals for each provider Tax-ID. The sub-totals and grand totals sum the number of line items and the total Allowed dollars.

REPORT PARAMETER OPTIONS:	Users may customize the report by selecting: All "Standard" parameters minus Match Type, Claim Type, Last Dates; Set Range (Set Owner Type, Claim Set Status; Adjustments, Date Type, FI, Region) plus Dupe Flag Indicator, Solicited Indicator, PTC Dates, Responsible FI, Region, Set Level User Defined Codes, Claim Level User Defined Codes, and Provider Tax ID. Users may customize the report by selecting: All claims or actual duplicate claims only (to be counted as an actual duplicate claim, it must have a "Y" Duplicate Flag value and be in a PENDING, VALIDATE, or CLOSED set); status (All, *Open*, *Pending*, *Closed*, *Validate*); only sets that have adjustments associated with them; multi-FI sets, single FI sets, or both; **set** match type (All, Exact, Near, Date Overlap, CPT-4, Other); a single processed-to-completion date or a range of processed-to- completion dates; a single load date or a range of load dates; one or all FIs; one, several or all regions within selected FIs. Users may also select one, several or all Provider Tax ID numbers to be included in the report.
REPORT NOTES:	Match types are applied at the line-item, claim, and set levels based on a hierarchy. The most stringent match type applicable is assigned at each level. The hierarchy for institutional claims is as follows: Exact, Near, Date Overlap and Other. For non-institutional claims, the hierarchy is as follows: Exact, Near, CPT-4, and Other. For both claim types, Exact Match criteria is the most stringent with Near Match next. Other Match is the least stringent. When the Duplicate Claims System identifies non- institutional potential duplicates, it is doing so at a **line item** level. When a line item is identified as a potential duplicate, the system labels the **line item** with the Match Type used to identify it as a potential duplicate. If a non-institutional **claim** contains line items identified as potential duplicates using more than one match type criteria (one line item identified under Exact Match criteria and another line item under CPT-4 criteria), the system uses the match type hierarchy and labels the **claim** with the most stringent match type appearing on the line items. If the **set** contains **claims** labeled with different match types (one claim labeled 'Near' and another labeled 'CPT-4'), the system uses the match type hierarchy and labels the **set** with the most stringent match type appearing on the claims.

Status Code = All
Adjust Type = All
Owner Type = All
Dupe Flag = All
Match Type = All
Owner FI = All
Owner Region = All
Resp FI = All
Resp Region = All
Provider Tax Codes = All
Set User Codes = All
Solicited = All
Claim User Codes = All

Date: 9/14/2007

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

ICN	TIME	SFX	USER CODE	S ?	SET#	DUP FLG	SPON SSAN	PATIENT NAME	DDS	LI Match	LI #	CPT-4 Code	AMT ALLOWED	PTC DATE	RESP FI
Tax ID: 555555555															
Sub ID: 0000															
19940462508505	000000	A			251	N	999999999	SMITH,JANE	20	C	4	99221	$90.70	3/10/1994	50
19942022508010	000000	A			251		999999999	SMITH,JANE	20	C	4	99291	$150.00	8/04/1994	50
19941640617670	000000	A			4899	N	999999999	SMITH,JANE	30	C	1	98330	$366.80	8/04/1994	50
19941640617670	000000	A			4899	N	999999999	SMITH,JANE	30	C	2	98335	$133.00	8/04/1994	50
19942340621783	000000	A			4899		999999999	SMITH,JANE	30	C	1	98310	$183.50	11/14/1194	99
19942340621783	000000	A			4899		999999999	SMITH,JANE	30	C	2	98315	$133.00	11/14/1194	99
									#Line Items				Allowed $		
								Sub ID Totals	6				$1,057.00		
Sub ID: A003															
19941362501086	000000	A			226		999999999	SMITH,JANE	20	C	1	90812	$90.00	10/13/1194	50
19942692501409	000000	A			226	N	999999999	SMITH,JANE	20	C	1	90844	$80.11	10/09/1994	50
19941362501086	000000	A			227		999999999	SMITH,JANE	20	C	2	90812	$90.00	10/13/1994	50
19942692501409	000000	A			226	N	999999999	SMITH,JANE	20	C	2	90844	$80.11	10/09/1994	50
									#Line Items				Allowed $		
								Sub ID Total	6				$1,057.00		
								Prov ID Totals	10				$1,397.22		

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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.

Status Code = All
Owner Type = All
Claim Type = All
Adjust Type = All
Match Type = All
Reason Codes = All
Owner FI = All
Owner Region = All
Resp FI = All
Resp Region = All
Set Number = All

Date: 9/14/2007

REASON CODE EXPLANATION REPORT
INDIVIDUAL CLAIMS

50 - Acme Claims Processing
Inactive - CA/HI 93C

SET #	STATUS	LOAD DATE	ICN	S	TIME	RESP FI	PTC DATE	DUP FLG	RSN CODE	REASON CODE EXPLANATION
22	V	09/24/1996	19933335170207	A	000000	50	12/07/1993	Y	D900	Test to Send to Pending

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REPORT CATEGORY:	Claim Report
REPORT MENU HIERARCHY AND FORMAT NAME:	REPORT ⇒CLAIM REPORTS ⇒**REASON CODE EXPLANATION ⇒ENTIRE SET**
PRINTED REPORT TITLE:	Reason Code Explanation Report Entire Set
REPORT DESCRIPTION:	This report provides a listing of the explanations associated with reason codes by set number. 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 explanations associated with the claims in a set. 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.

Status Code = All
Owner Type = All
Claim Type = All
Adjust Type = All
Match Type = All
Owner FI = All
Owner Region = All
Resp FI = All
Resp Region = All
100 >= Set Number <= 500
Reason Codes = All

Date: 9/14/2007

REASON CODE EXPLANATION REPORT
ENTIRE SET

50 - Acme Claims Processing

Area 1

SET#	STATUS	LOAD DATE
511	O	12/16/1996

ICN	S	TIME	RESP FI	PTC DATE	DUPE FLAG	RSN CODE	REASON CODE
19942132278483	A	000000	50	8/15/1994	N	BASE	
19942282275147	A	000000	50	8/26/1994			
19942562275780	A	000000	50	10/10/1994			

55 - East West Claims

Undetermined Region

SET#	STATUS	LOAD DATE
371	O	8/24/2007

ICN	S	TIME	RESP FI	PTC DATE	DUPE FLAG	RSN CODE	REASON CODE
19941585303498	A	000000	50	9/27/1994			
19942165305253	A	000000	55	9/29/1994	N	BASE	

73 - HAL Systems Inc

Area 73D

SET#	STATUS	LOAD DATE
578	O	1/28/1997

ICN	S	TIME	RESP FI	PTC DATE	DUPE FLAG	RSN CODE	REASON CODE
19941510414565	A	000000	50	7/11/1994	N	BASE	
19941510414566	A	000000	50	7/14/1994			
19942550410610	A	000000	73	10/7/1994			
19942550410611	A	000000	73	10/7/1994			

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REPORT CATEGORY:	Claim Report
REPORT MENU HIERARCHY AND FORMAT NAME:	REPORT ⇒CLAIM REPORTS ⇒**ADJUSTMENTS**
PRINTED REPORT TITLE:	Claims With Associated Adjustments
REPORT DESCRIPTION:	This report provides a listing of claims, grouped in their respective sets, with any associated adjustment claims which have been submitted. Only sets which contain one or more claims that have associated adjustments will be listed. The fields displayed on the report are: Set Number; ICN; HCSR Suffix; HCSR Time Stamp; Dupe Flag Indicator; Reason Code; Responsible FI; Sponsor SSAN; Patient Name; DEERS Dependent Suffix; Provider Tax ID; Provider Sub-ID; Claim Level Allowed; Line Item Number; Line Item Allowed Amount; Adjustment Flag; Adjustment Line Item; and Adjustment Allowed Amount.
REPORT PARAMETER OPTIONS:	Users may customize the report by selecting: All "Standard" parameters minus Adjustments (Claim Set Status, Set Owner Type, Claim Type, Match Type, Date Type, Set Range, FI, Region) plus PTC Dates, Responsible FI, Region, Claim Level User Defined Codes.
REPORT NOTES:	The data used by this report format is claim and line item level data.

Status Code = All
Owner Type = All
Claim Type = All
Match Type = All
100 >= Set Number <= 300
Owner FI = All
Owner Region = All
Resp FI = All
Resp Region = All
Claim User Codes = All

Date: 9/14/2007

CLAIMS WITH ASSOCIATED ADJUSTMENTS

Set#	ICN	Sfx	Hcsr Time	Dup ?	RSN Code	Resp FI	Spon Ssan	Patient Name	DDS Code	Prov ID	Prov Sub Id	Amt Allowed	Line Item	Amt Allowed CPT4
50 - Acme Claims Processing														
121	19942065400200	A	000000			50	999999999	SMITH,LESLIE,X	30	555555555	0000	307.10	1	13.04
										Adjust Flag	**Adjust Line Item**		**Adjustment Allowed Amount**	
											1		($13.04)	
											2		($117.08)	
121	19942065400200	A	000000			50	999999999	SMITH,LESLIE,X	30	555555555	0000	307.10	2	117.08
										Adjust Flag	**Adjust Line Item**		**Adjustment Allowed Amount**	
											1		($13.04)	
											2		($117.08)	
122	19942065400200	A	000000			50	999999999	SMITH,LESLIE,X	30	555555555	0000	307.10	3	125.08
										Adjust Flag	**Adjust Line Item**		**Adjustment Allowed Amount**	
											3		($125.08)	
123	19942065400200	A	000000			50	999999999	SMITH,LESLIE,X	30	555555555	0000	307.10	4	51.90
										Adjust Flag	**Adjust Line Item**		**Adjustment Allowed Amount**	
											4		($51.90)	

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REPORT CATEGORY:	Claim Report
REPORT MENU HIERARCHY AND FORMAT NAME:	REPORT ⇒CLAIMS ⇒WORK SHEETS ⇒**INSTITUTIONAL**
PRINTED REPORT TITLE:	Institutional Claims Worksheet
REPORT DESCRIPTION:	This report resembles the paper duplicate claims reports provided to contractors in the past. This report lists institutional claim sets 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 institutional claims. The fields displayed on the report are: Owner FI; Region; ICN; HCSR Suffix; Set Level User Defined Code; Solicited Indicator; Set Number; PTC Date; Responsible FI; Sponsor SSAN; Patient Name; DEERS Dependent Suffix; Provider Tax ID; Provider Sub-ID; Diagnosis; DRG; Amount Billed; Amount Allowed; Government Paid Amount; Dupe Flag?; Reason Code; ID Recoupment 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 Adjustments (Claim Set Status, Set Owner Type, Claim 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 claim level data.

Adjust Type = All
Owner Type = All
Match Type = All
Solicited = All
100 >= Set Number <= 4500
Owner FI = All
Owner Region = All
Resp FI = All
Resp Region = All

Date: 9/14/2007

INSTITUTIONAL CLAIMS WORKSHEET

50 - Acme Claims Processing

Area 1

ICN	S FX	USR CD	S?	SET#	PTC DATE	RS FI	SPON SSAN	PATIENT NAME	DDS	PROV TAX ID	PROV SUBID	DIAG	DRG	AMT BILLED	AMT ALLOWED	NET GOVT PAID AMT	DUPE ? (Y/N)	RSN CD	RECOUP/ RFND AMT
19931725370509	A			104	10/26/1993	50	999999999	SMITH, JANE	31	555555555	0000	65421	371	$3,604.00	$2,645.96	$2,618.06	-----	-----	---------
19931725370509	B			104	10/18/1994	50	999999999	SMITH, JANE	31	555555555	0000	65421	374	$3,604.00	$2,253.18	$2,225.28	-----	-----	---------
19942451009748	A			3411	11/06/1994	50	999999999	SMITH, JANE	01	555555555	0000	311	000	$5,998.44	$3,808.00	$2,752.00	-----	-----	---------
19943071008101	A			3411	11/10/1994	50	999999999	SMITH, JANE	01	555555555	0000	311	426	$3,605.00	$3,332.00	$2,430.75	-----	-----	---------
19940474270059	A			3461	03/04/1994	73	999999999	SMITH, JANE	04	555555555	0000	76510	000	$28,859.00	$28,859.00	$28,803.20	-----	-----	---------
19942844200023	A			3461	11/08/1994	50	999999999	SMITH, JANE	04	555555555	0000	V3000	607	$30,340.20	$12,295.96	$12,295.96	-----	-----	---------
19950334208001	A			3461	02/20/1995	50	999999999	SMITH, JANE	04	555555555	0000	V3000	607	$30,340.20	$12,295.96	$12,295.96	-----	-----	---------

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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.

Adjust Type = All
Owner Type = All
Match Type = All
Solicited = All
100 >= Set Number <= 600
Owner FI = All
Owner Region = All
Resp FI = All
Resp Region = All

Date: 9/14/2007

NON-INSTITUTIONAL CLAIMS WORKSHEET

50 - Acme Claims Processing

Area 1

ICN	S FX	USR	S ?	SET #	RS FI	SPON SSAN	PATIENT NAME	DDS	PROVIDER TAX ID	PROV SUB-ID	DIAG	LI	CPT-4 CODE	AMT BILLED CPT-4 CD	AMT ALD CPT-4 CD	DUPE? (Y/N)	RSN CD	RECOUP/ RFND AMT
19941925400374	A			122	50	999999999	SMITH, JANE	30	555555555	0000	486	2	99231	$200.00	$125.08	-----	-----	---------
19942065400200	A			122	50	999999999	SMITH, JANE	30	555555555	0000	486	3	99231	$200.00	$125.08	-----	-----	---------

55 - East West Claims

Undetermined Region

ICN	S FX	USR	S ?	SET #	RS FI	SPON SSAN	PATIENT NAME	DDS	PROVIDER TAX ID	PROV SUB-ID	DIAG	LI	CPT-4 CODE	AMT BILLED CPT-4 CD	AMT ALD CPT-4 CD	DUPE? (Y/N)	RSN CD	RECOUP/ RFND AMT
19941585303498	A			371	50	999999999	SMITH, JANE	30	555555555	A001	6800	1	99213	$55.00	$32.82	-----	-----	---------
19942165305253	A			371	55	999999999	SMITH, JANE	30	555555555	A001	6800	1	99213	$55.00	$32.82	-----	-----	---------

73 - HAL Systems Inc

Area 73D

ICN	S FX	USR	S ?	SET #	RS FI	SPON SSAN	PATIENT NAME	DDS	PROVIDER TAX ID	PROV SUB-ID	DIAG	LI	CPT-4 CODE	AMT BILLED CPT-4 CD	AMT ALD CPT-4 CD	DUPE? (Y/N)	RSN CD	RECOUP/ RFND AMT
19942550410611	A			578	73	999999999	SMITH, JANE	30	555555555	0000	V242	1	86430	$28.73	$22.70	-----	-----	---------
19942550410611	A			578	73	999999999	SMITH, JANE	30	555555555	0000	V242	2	86038	$47.25	$34.00	-----	-----	---------
19942550410611	A			578	73	999999999	SMITH, JANE	30	555555555	0000	V242	3	85651	$16.00	$10.00	-----	-----	---------
19942550410611	A			578	73	999999999	SMITH, JANE	30	555555555	0000	V242	4	84550	$17.50	$17.40	-----	-----	---------
19942550410611	A			578	73	999999999	SMITH, JANE	30	555555555	0000	V242	5	84436	$30.00	$24.00	-----	-----	---------

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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.

9/14/2007

CLAIM LEVEL USER DEFINED FIELD DEFINITIONS

Owner FI	Contract #	Code	Description	Active ?
50	50C0004	2B	Testing - 2B	Y

Owner FI	Contract #	Code	Description	Active ?
63	63D0004	2B	Tesing	Y
63	63D0004	88	t	Y

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REPORT CATEGORY:	Summary/Management
REPORT MENU HIERARCHY AND FORMAT NAME:	REPORT ⇒SUMMARY/MANAGEMENT REPORTS ⇒**INST BY DUPLICATE TYPE**
PRINTED REPORT TITLE:	Institutional Summary Report Potentials/Actuals/Non-Duplicates By Contractor (grouped by Region)
REPORT DESCRIPTION:	This summary/management report shows the total number of institutional potential duplicates, actual duplicates, non-duplicates, and those not yet worked by the contractor for the initial or current load date selected or load date range specified by the user. The report lists the number of claims and the amount paid by match type. The report also shows the number of actual duplicates, non-duplicates, and potential duplicate claims as a percentage of the total number of potential duplicates loaded. For this report, potential duplicates are the universe of all non-base claims. Actual duplicates are those claims with a "Y" dupe flag in *Pending*, *Validate,* or *Closed* status. Non-duplicates are those non-base claims with an "N" dupe flag in *Pending*, *Validate,* or *Closed* status. Potential duplicates not worked are non-base claims in *Open* status irrespective of any dupe flag value. The dollar totals on the report are for non- base claims only.
REPORT PARAMETER OPTIONS:	Users may customize the report by selecting: All "Standard" parameters minus Claim Set Status; Claim Types; Match Types; Last Dates; Set Range (Adjustments, Set Owner Type, Date Type, Set Range, FI, Region) plus Responsible FI, and Region, and Risk Indicator.
REPORT NOTES:	The data used by this report format is claim level data. It should be noted that the total number of claims and percentages shown on this report may differ from that shown on the "Actual vs. Potential" graph report. Any discrepancy will be due to the fact that this report will count a claim more than once if it appears in two or more sets owned by the same region but which have different match types. The graph, alternatively, will not count a claim more than once if it appears in two or more sets owned by the same region.

Adjust Type = All
Owner Type = All
Owner FI = All
Owner Region = All
Resp FI = All
Resp Region = All
Risk Ind = All

Date: 9/17/2007

INSTITUTIONAL SUMMARY REPORT
POTENTIALS/ACTUALS/NON-DUPLICATES
BY FI/CONTRACTOR
(GROUPED BY REGION)

Set Match Type	Number of Potential Dupes	Potential Dupes $	Number of Actual Dupes	Actual Dupes % of Potential	Actual Dupes Amount Paid Govt Contr	Number of Non-Dupe Claims	Non -Dupes % of Potential	Non Dupes Amount Paid Govt Contr	Number of Potential Not Worked Claims	Not Worked % of Potential	Potential Not Worked Amount Paid Govt Contr
50 - Acme Claims Processing											
Area 1											
Date Overlap	29	$355,935.01	1	3.4%	$1,090.44	0	0.0%	$0.00	28	96.6%	$354,844.57
Exact	14	$81,515.72	0	0.0%	$0.00	0	0.0%	$0.00	14	100.0%	$81,515.72
Near	16	$123,404.94	0	0.0%	$0.00	0	0.0%	$0.00	16	100.0%	$123,404.94
Other	4	$10,755.95	0	0.0%	$0.00	0	0.0%	$0.00	4	100.0%	$10,755.95
Region	63		1	1.6%		0	0.0%		62	98.4%	
Totals		$571,611.62			$1,090.44			$0.00			$570,521.18
99 - Inactive Contractor											
Inactive - CA/HI 88C											
Near	0	$0.00	0	0.0%	$0.00	0	0.0%	$0.00	0	0.0%	$0.00
Region	0		0	0.0%		0	0.0%		0	0.0%	
Totals		$0.00			$0.00			$0.00			$0.00

Note: These are counts of individual non-base claims.These dollar totals do not include base claims.

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REPORT CATEGORY:	Summary/Management
REPORT MENU HIERARCHY AND FORMAT NAME:	REPORT ⇒SUMMARY/MANAGEMENT REPORTS ⇒ **NONINST BY DUPLICATE TYPE**
PRINTED REPORT TITLE:	Non-Institutional Summary Report Potentials/Actuals/Non-Duplicate By Contractor (grouped by Region)
REPORT DESCRIPTION:	This summary/management report shows the total number of non-institutional potential duplicates, actual duplicates, non-duplicates, and those not yet worked by the contractor for the initial or current load dates selected or load date range specified by the user. The report lists the number of claims and the allowed amounts paid by match type. The report also shows the number of actual duplicates, non-duplicates, and potential duplicate claims as a percentage of the total number of potential duplicates loaded. This report differs from the institutional report in significant ways due to the following: 1) non-institutional claims involve line-items where institutional claims do not; and 2) non-institutional line-items on the HCSRs do not carry amounts paid but only allowed amounts. In the Automated TRICARE Duplicate Claims System institutional claims will never appear in more than one set. Non-institutional **claims** may appear in more than one set since the system is identifying potential duplicates at a line-item level and not at a claim level as it does for institutional claims. The system creates non-institutional claim sets based on the dates of service of the line-items in question. By grouping potential duplicate non-institutional line items into sets based on the dates of service of the line items in question, the system avoids identifying two office visits for the same beneficiary occurring on different dates of service as potential duplicates. However, by grouping line items into sets based on dates of service, the possibility exists that a claim containing line items with different dates of service will appear in more than one set (the claim with the line item with one date of service appearing in one set and the same claim with the line item with the other date of service appearing in another).

REPORT DESCRIPTION: (CONTINUED)	This report does not count unique claims but rather all non-base claims appearing in sets with a particular match type, i.e., the total number of non-base claims appearing in CPT-4, Exact, Near, and Other match type sets. Since a non-institutional **claim** may appear in more than one set, the counts of the **claims** appearing on this report may be inflated. The dollars shown on this report, however, are not inflated since a line-item will never appear in more than one set. As a result, the dollars appearing on this report are the allowed amounts for the line items appearing in the sets in which their host claim appears. While the host claim may be counted more than once, the dollar amounts associated with the line items will not be counted more than once. For this report, potential duplicates are the universe of all non-base claims. Actual duplicates are those claims with a "Y" dupe flag in *Pending*, *Validate,* or *Closed* status. Non-duplicates are those non-base claims with an "N" dupe flag in *Pending*, *Validate,* or *Closed* status. Potential duplicates not worked are non-base claims in *Open* status irrespective of any dupe flag value. The dollar totals on the report are for non-base claims only.
REPORT PARAMETER OPTIONS:	Users may customize the report by selecting: All "Standard" parameters minus Claim Set Status, Claim Types, Match Types, Last Dates, Set Range (Adjustments, Set Owner Type, Date Type, Set Range, FI, Region) plus Responsible FI, Region, and Risk Indicator.
REPORT NOTES:	The data used by this report format is claim level and line-item data. It should be noted that the total number of claims and percentages shown on this report may differ from that shown on the "Actual vs. Potential" graph report. Any discrepancy will be due to the fact that this report will count a claim more than once if it appears in two or more sets owned by the same region but which have different match types. The graph, alternatively, will not count a claim more than once if it appears in two or more sets owned by the same region.

Adjust Type = All
Owner Type = All
Owner FI = All
Owner Region = All
Resp FI = All
Resp Region = All
Risk Ind = All

INSTITUTIONAL SUMMARY REPORT
POTENTIALS/ACTUALS/NON-DUPLICATES
BY FI/CONTRACTOR
(GROUPED BY REGION)

Date: 9/17/2007

Set Match Type	Number of Potential Dupes	Potential Dupes $	Number of Actual Dupes	Actual Dupes % of Potential	Actual Dupes Amount Paid Govt Contr	Number of Non-Dupe Claims	Non -Dupes % of Potential	Non Dupes Amount Paid Govt Contr	Number of Potential Not Worked Claims	Not Worked % of Potential	Potential Not Worked Amount Paid Govt Contr
50 - Acme Claims Processing											
Area 1											
CPT-4	3	$566.50	0	0.0%	$0.00	0	0.0%	$0.00	3	100.0%	$556.50
Exact	21	$6,903.04	0	0.0%	$0.00	0	0.0%	$0.00	21	100.0%	$6,903.04
Near	18	$6,215.42	0	0.0%	$0.00	0	0.0%	$0.00	18	100.0%	$6,215.42
Other	8	$6,313.92	0	0.0%	$0.00	0	0.0%	$0.00	8	100.0%	$6,313.92
Region	50		0	0.0%		0	0.0%		50	100.0%	
Totals		$19,988.88			$0.00			$0.00			$19,988.88
51 - Claims 'R' Us											
Area 51											
Near	2	$1,451.95	0	0.0%	$0.00	0	0.0%	$0.00	2	100.0%	$1,451.95
Region	2		0	0.0%		0	0.0%		2	100.0%	
Totals		$1,451.95			$0.00			$0.00			$1,451.95
55 - East West Claims											
Undetermined Region											
Exact	1	$32.82	0	0.0%	$0.00	0	0.0%	$0.00	1	100.0%	$32.82
Region	1		0	0.0%		0	0.0%		1	100.0%	
Totals		$32.82			$0.00			$0.00			$32.82

Note: These are counts of individual non-base claims.These dollar totals do not include base claims.

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REPORT CATEGORY:	Summary/Management Report
REPORT MENU HIERARCHY AND FORMAT NAME:	REPORT ⇒SUMMARY/MANAGEMENT REPORTS ⇒**SET AGING REPORT**
PRINTED REPORT TITLE:	Set Aging Report
REPORT DESCRIPTION:	This report provides the total number of sets in *Open*, *Pending*, *Validate*, and *Closed s*tatus grouped by region and either initial or current load date (depending on which is selected) as of the date the report is run. The report also shows the percentage each total represents of the total number of sets counted. The fields displayed on the report are: Owner FI; Region; Initial or Current Load Date; Number and Percentage of *Open* Sets; Number and Percentage of *Pending* Sets; Number and Percentage of *Validate* Sets; Number and Percentage of *Closed* Sets; and the Total Number of Sets. The report provides sub-totals for each contract region and grand totals for each contractor.
REPORT PARAMETER OPTIONS:	Users may customize the report by selecting: All "Standard" parameters minus Status, Last Dates, Set Range (Adjustments, Set Owner Type, Claim Type, Match Type, Date Type, FI, Region).
REPORT NOTES:	The data used by this report format is set level data.

Adjust Type = All
Claim Type = All
Owner Type = All
Match Type = All
Owner FI = All
Owner Region = All

Date: 9/17/2007

SET AGING REPORT

Initial Load Date	Open Sets		Pending Sets		Validate Sets		Closed Sets		Total Sets
50 - Acme Claims Processing									
Area 1									
09/1996	103	93.6%	0	0.0%	1	0.9%	6	5.5%	110
Sub Total	103	93.6%	0	0.0%	1	0.9%	6	5.5%	110
FI Total	103	93.6%	0	0.0%	1	0.9%	6	5.5%	110
51 - Claims 'R' Us									
Area 51									
09/1996	1	100.0%	0	0.0%	0	0.0%	0	0.0%	1
Sub Total	1	100.0%	0	0.0%	0	0.0%	0	0.0%	1
FI Total	1	100.0%	0	0.0%	0	0.0%	0	0.0%	1
55 - East West Claims									
Undetermined Region									
09/1996	1	100.0%	0	0.0%	0	0.0%	0	0.0%	1
Sub Total	1	100.0%	0	0.0%	0	0.0%	0	0.0%	1
FI Total	1	100.0%	0	0.0%	0	0.0%	0	0.0%	1
73 - HAL Systems Inc									
Area 73D									
09/1996	1	100.0%	0	0.0%	0	0.0%	0	0.0%	1
Sub Total	1	100.0%	0	0.0%	0	0.0%	0	0.0%	1
FI Total	1	100.0%	0	0.0%	0	0.0%	0	0.0%	1
99 - Inactive Contractor									
Inactive - CA/HI 93C									
09/1996	1	100.0%	0	0.0%	0	0.0%	0	0.0%	1
Sub Total	1	100.0%	0	0.0%	0	0.0%	0	0.0%	1
Inactive - CA/HI 88C									
09/1996	0	0.0%	0	0.0%	0	0.0%	1	100.0%	1
Sub Total	0	0.0%	0	0.0%	0	0.0%	1	100.0%	1
FI Total	1	50.0%	0	0.0%	0	0.0%	1	50.0%	2
Grand Total	107	93.0%	0	0.0%	1	0.9%	7	6.1%	115

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REPORT CATEGORY:	Summary/Management Report
REPORT MENU HIERARCHY AND FORMAT NAME:	REPORT ⇒SUMMARY/MANAGEMENT REPORTS ⇒**CLAIM AGING REPORT**
PRINTED REPORT TITLE:	Claim Aging Report
REPORT DESCRIPTION:	This report provides the total number of non-base claims in *Open* Status (Not Worked), the total number of actual duplicate claims ('Y' Duplicate Flag Value in *Pending*, *Validate,* and *Closed* status) and the total number of non-duplicate claims ('N' Duplicate Flag Value in *Pending*, *Validate,* and *Closed* status) as of the date the report is run. The report also provides the total allowed amounts of the non-base claims in *Open* Status (Not Worked), the total amounts identified for recoupment and actually recouped of the actual duplicate claims, and the total allowed amounts of the non-duplicate claims. The report shows claim counts but for non-institutional claims the allowed amount totals are the sum of the line-item allowed amounts in the system. The report is grouped by Initial or Current Load Date (depending on which is selected) and region and provides sub-totals by region and grand totals by contractor.
REPORT PARAMETER OPTIONS:	Users may customize the report by selecting: All "Standard" parameters minus Status; Last Dates; Set Range (Adjustments, Set Owner Type, Claim Type, Match Type, Date Type, FI, Region) plus Responsible FI and Region.
REPORT NOTES:	The data used by this report format is claim level data.

Adjust Type = All
Claim Type = All
Owner Type = All
Match Type = All
Owner FI = All
Owner Region = All
Resp FI = All
Resp Region = All

Date: 9/17/2007

CLAIM AGING REPORT

Initial Load Date	Not Worked #Claims	Not Worked Allowed Amount	Actual Dupes #Claims	Actual Dupes ID Recoup	Actual Dupes Actual Recoup	Non Dupes #Claims	Not Dupes Allowed Amount
50 - Acme Claims Processing							
Area 1							
09/1996	120	$627,003.22	1	$2,000.00	$1,115.44	0	$0.00
Sub Totals	120	$627,003.22	1	$2,000.00	$1,115.44	0	$0.00
FI Totals	120	$627,003.22	1	$2,000.00	$1,115.44	0	$0.00
51 - Claims 'R' Us							
Area 51							
09/1996	2	$1,451.95	0	$0.00	$0.00	0	$0.00
Sub Totals	2	$1,451.95	0	$0.00	$0.00	0	$0.00
FI Totals	2	$1,451.95	0	$0.00	$0.00	0	$0.00
55 - East West Claims							
Undetermined Region							
09/1996	1	$32.82	0	$0.00	$0.00	0	$0.00
Sub Totals	1	$32.82	0	$0.00	$0.00	0	$0.00
FI Totals	1	$32.82	0	$0.00	$0.00	0	$0.00
99 - Inactive Contractor							
Inactive - CA/HI 88C							
09/1996	0	$0.00	0	$0.00	$0.00	0	$0.00
Sub Totals	0	$0.00	0	$0.00	$0.00	0	$0.00
Inactive - CA/HI 93C							
09/1996	2	$951.41	0	$0.00	$0.00	0	$0.00
Sub Totals	2	$951.41	0	$0.00	$0.00	0	$0.00
FI Totals	2	$951.41	0	$0.00	$0.00	0	$0.00
Grand Totals	125	$629,439.40	1	$2,000.00	$1,115.44	0	$0.00

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REPORT CATEGORY:	Summary/Management Report
REPORT MENU HIERARCHY AND FORMAT NAME:	REPORT ⇒SUMMARY/MANAGEMENT REPORTS ⇒ **ARCHIVED SET REPORT**
PRINTED REPORT TITLE:	Archived Set Report
REPORT DESCRIPTION:	This report provides the total number of sets in the History Database in *Validate* and *Closed* Status grouped by region and Initial Load Date as of the date the report is run. While the report contains columns for *Open* status and *Pending* status, these will always be 0% since sets in *Open* and *Pending* status are never archived to the History Database. The report also shows the percentage each total represents of the total number of sets counted. The fields displayed on the report are: Owner FI; Region; Initial Load Date; Number and Percentage of *Open* Sets; Number and Percentage of *Pending* Sets; Number and Percentage of *Validate* Sets; Number and Percentage of *Closed* Sets; and the Total Number of Sets. The report provides sub-totals for each contract region and grand totals for each contractor.
REPORT PARAMETER OPTIONS:	Users may customize the report by selecting: All "Standard" parameters minus Status, Last Dates, Current Load Dates, Set Range (Adjustments, Set Owner Type, Claim Type, Match Type, Date Type, FI, Region).
REPORT NOTES:	The data used by this report format is set level data.

Adjust Type = All
Owner Type = All
Claim Type = All
Match Type = All
Owner FI = 03
Owner Region = All

ARCHIVED SET REPORT

Date: 9/17/2007

Initial Load Date	Validate Sets		Closed Sets		Total Sets
03 - Humana MHS					
Undetermined Region					
4/97	1	100.0%	0	0.0%	1
6/97	0	0.0%	1	100.0%	1
7/97	0	0.0%	1	100.0%	1
8/97	1	50.0%	1	50.0%	2
9/97	0	0.0%	2	100.0%	2
10/97	2	66.7%	1	33.3%	3
11/97	0	0.0%	1	100.0%	1
12/97	0	0.0%	8	100.0%	8
1/98	0	0.0%	2	100.0%	2
2/98	2	33.3%	4	66.7%	6
3/98	1	50.0%	1	50.0%	2
4/98	0	0.0%	1	100.0%	1
5/98	5	71.4%	2	28.6%	7
6/98	0	0.0%	3	100.0%	3
7/98	0	0.0%	2	100.0%	2
8/98	2	28.6%	5	71.4%	7
Sub Total	**14**	28.6%	**35**	71.4%	**49**
Region 3, 4					
4/97	1418	8.1%	16187	91.9%	17605
6/97	45	2.8%	1565	97.2%	1610
7/97	9	1.1%	784	98.9%	793
8/97	13	1.3%	968	98.7%	981
9/97	6	0.8%	773	99.2%	779
10/97	5	1.0%	515	99.0%	520
11/97	3	0.5%	663	99.5%	666
12/97	10	1.3%	767	98.7%	777
1/98	4	0.7%	564	99.3%	568
2/98	12	1.8%	650	98.2%	662
3/98	13	1.5%	853	98.5%	866
4/98	5	0.6%	781	99.4%	786
5/98	4	0.7%	609	99.3%	613
6/98	11	1.7%	642	98.3%	653
7/98	4	0.6%	668	99.4%	672
8/98	53	5.5%	914	94.5%	967
Sub Total	**1615**	5.5%	**27903**	94.5%	**29518**
FI Total	**1629**	5.5%	**27938**	94.5%	**29567**

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REPORT CATEGORY:	Summary/Management Report
REPORT MENU HIERARCHY AND FORMAT NAME:	REPORT ⇒SUMMARY/MANAGEMENT REPORTS ⇒**REASON CODE REPORT**
PRINTED REPORT TITLE:	Reason Code Report
REPORT DESCRIPTION:	This report provides a list of actual duplicate and non-duplicate reason codes and the total number claims to which each code was assigned. The report counts actual duplicate claims ('Y' Duplicate Flag value) and non-duplicate claims ('N' Duplicate Flag value) in Pending, Validate and Closed sets.
REPORT PARAMETER OPTIONS:	Users may customize the report by selecting: All "Standard" parameters minus Claim Set Status (Adjustments, Set Owner Type, Claim Type, Match Type, Date Type, Set Range, FI, Region) plus Dupe Indicator, Solicited Indicator, Exclude Base, PTC Dates, Set Level User Defined Code, Claim Level User Defined Code, Responsible FI, Region, and Risk Indicator.
REPORT NOTES:	The data used by this report format is claim level data.

Status Codes = P or V or C
Adjust Type = All
Owner Type = All
Claim Type = All
Match Type = All
Dupe Flag = All
Owner FI = All
Owner Region = All
Resp FI = All
Resp Region = All
Set Number = All
Exclude Base Claims = No
Solicited = All
Set User Codes = All
Claim User Codes = All
Risk Ind = All

Date: 9/17/2007

REASON CODE REPORT

Reason Code		Number of Claims
BASE	Initial submission	8
D300	Other	1
	Total:	**9**

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REPORT CATEGORY:	Summary/Management Report
REPORT MENU HIERARCHY AND FORMAT NAME:	REPORT ⇒SUMMARY/MANAGEMENT REPORTS ⇒**REASON CODE BY INIT LOAD DATE**
PRINTED REPORT TITLE:	Reason Code Report by Initial Load Date
REPORT DESCRIPTION:	This report provides a list of actual duplicate and non-duplicate reason codes and the total number claims to which each code was assigned. The report counts actual duplicate claims ('Y' Duplicate Flag value) and non-duplicate claims ('N' Duplicate Flag value) in Pending, Validate and Closed sets. The report is grouped by Initial Load Date.
REPORT PARAMETER OPTIONS:	This report provides a list of actual duplicate and non-duplicate reason codes and the total number claims to which each code was assigned. The report counts actual duplicate claims ('Y' Duplicate Flag value) and non-duplicate claims ('N' Duplicate Flag value) in Pending, Validate and Closed sets. The report is grouped by Initial Load Date.
REPORT NOTES:	Users may customize the report by selecting: All "Standard" parameters minus Claim Set Status (Adjustments, Set Owner Type, Claim Type, Match Type, Date Type, Set Range, FI, Region) plus Dupe Flag Indicator, Solicited Indicator, Exclude Base, PTC Dates, Set and Claim Level User Defined Codes, Responsible FI, and Region.

Status Codes = P or V or C
Adjust Type = All
Owner Type = All
Exclude Base Claims = No
Claim Type = All
Match Type = All
Dupe Flag = All
Owner FI = All
Owner Region = All
Resp FI = All
Resp Region = All
Set Number = All
Solicited = All
Set User Codes = All
Claim User Codes = All
Risk Ind = All

Date: 9/17/2007

REASON CODE REPORT
BY INITIAL LOAD DATE

Initial Load Date
09/1996

Reason Code		Number of Claims
BASE	Initial submission	8
D300	Other	1
	Total:	**9**
	Grand Total	**9**

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REPORT CATEGORY:	Summary/Management Report
REPORT MENU HIERARCHY AND FORMAT NAME:	REPORT ⇒SUMMARY/MANAGEMENT REPORTS ⇒**MODIFY FI**
PRINTED REPORT TITLE:	Changed Owner FI Sets
REPORT DESCRIPTION:	This report identifies multi-contractor sets which have had their ownership changed through the use of the "Modify FI" function on the system menu bar. It does not show multi-contractor sets which have had their ownership changed by the mass change process. The fields displayed on the report are: Set Number; Contractor; Changed Date; and User. The report shows each instance ownership of a multi-contractor set was changed; the name of the new owner contractor, the date ownership was changed, and the application User ID of the user who made the change. The first record listed for each set on the report shows the User as 'INITLOAD.' This means that the set was initially loaded by the system.
REPORT PARAMETER OPTIONS:	Users may customize the report by selecting: All "Standard" parameters minus Set Owner Type and Last Date (Claim Set Status Adjustments, Claim Type, Match Type, Date Type, Set Range, FI, Region) plus PTC Dates, Exclude Base, and Set Range.
REPORT NOTES:	The data used by this report format is set level data. Single-line entries with "INITLOAD" as the user may appear on this report. These single-line entries will appear for sets where a user has begun the process of changing (modifying) ownership of the multi-contractor set, enters the reason for making the change, presses the **UPDATE CHANGES** button, but decides to "rollback" the changes, i.e., does not complete changing the set's ownership. Such sets will be listed on this report as a single-line entry with "INITLOAD" as the user.

Status Code = All
Adjust Type = All
Claim Type = All
Match Type = All
2000 >= Set Number <= 3000
Owner FI = 03
Owner Region = All

Date: 9/17/2007

CHANGED OWNER FI SETS

Set Number	FI/Contractor	Changed Date	User
2204		04/14/1997	INITLOAD
2204		04/14/1997	SYSTEM
2204	06 - Health Net Federal Services	04/14/1997	SYSTEM
2204	03 - Humana MHS	01/14/1998	WPSHUNER
2204	06 - Health Net Federal Services	03/01/1999	HMSPOOLE
2204	03 - Humana MHS	03/01/1999	WPSHUNER
2645		04/14/1997	INITLOAD
2645	03 - Humana MHS	04/14/1997	SYSTEM
2645	25 - Humana MHS	08/07/2006	mshapiro
2645	03 - Humana MHS	02/26/2007	cnolan
2645	25 - Humana MHS	03/12/2007	pprsqt07
2645	03 - Humana MHS	03/12/2007	pprsqt09

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REPORT CATEGORY:	Summary/Management Report
REPORT MENU HIERARCHY AND FORMAT NAME:	REPORT ⇒SUMMARY/MANAGEMENT REPORTS ⇒**SET STATUS COUNT HISTORY**
PRINTED REPORT TITLE:	Set Status Count History
REPORT DESCRIPTION:	This report provides a count and percentage of sets within each status as of a date or range of dates grouped by contract.
REPORT PARAMETER OPTIONS:	Users may customize the report by selecting: Responsible FI, Region, and As of Dates.
REPORT NOTES:	The data used by this report format is set level data.

SET STATUS COUNT HISTORY

Date: 9/17/2007

FOR PERIOD FROM 01/01/2001 TO 02/10/2004

Owner FI = 03

Owner Region = All

0 - Humana MHS

Undetermined Region

ON	OPEN SETS	%	PENDING SETS	%	VALIDATE SETS	%	CLOSED SETS	%	TOTAL	%
01/01/2004	1516	86.0%	100	5.7%	51	2.9%	96	5.4%	1763	100.0%
01/02/2004	1516	86.0%	100	5.7%	51	2.9%	96	5.4%	1763	100.0%
01/03/2004	1519	86.0%	100	5.7%	51	2.9%	96	5.4%	1766	100.0%
01/04/2004	1521	86.0%	100	5.7%	51	2.9%	96	5.4%	1768	100.0%
01/05/2004	1521	86.0%	100	5.7%	51	2.9%	96	5.4%	1768	100.0%
01/06/2004	1520	85.9%	102	5.8%	51	2.9%	96	5.4%	1769	100.0%
01/07/2004	1520	85.9%	102	5.8%	51	2.9%	96	5.4%	1769	100.0%
01/08/2004	1520	85.9%	102	5.8%	51	2.9%	96	5.4%	1769	100.0%
01/09/2004	1516	86.0%	99	5.6%	51	2.9%	96	5.4%	1763	100.0%
01/10/2004	1525	86.1%	99	5.6%	51	2.9%	96	5.4%	1771	100.0%
01/11/2004	1527	86.1%	99	5.6%	51	2.9%	96	5.4%	1773	100.0%
01/12/2004	1527	86.1%	99	5.6%	51	2.9%	96	5.4%	1773	100.0%
01/13/2004	1532	86.2%	99	5.6%	51	2.9%	96	5.4%	1778	100.0%
01/14/2004	1535	86.2%	99	5.6%	51	2.9%	96	5.4%	1781	100.0%
01/15/2004	1537	86.2%	99	5.6%	51	2.9%	96	5.4%	1783	100.0%
01/16/2004	1543	86.2%	99	5.5%	51	2.9%	96	5.4%	1789	100.0%
01/17/2004	1549	86.3%	99	5.5%	51	2.8%	96	5.3%	1795	100.0%

Region 3,4

ON	OPEN SETS	%	PENDING SETS	%	VALIDATE SETS	%	CLOSED SETS	%	TOTAL	%
01/01/2004	53835	25.5%	22153	10.5%	15992	7.6%	118941	56.4%	210921	100.0%
01/02/2004	53835	25.5%	22153	10.5%	15992	7.6%	118941	56.4%	210921	100.0%
01/03/2004	53805	25.5%	22159	10.5%	15995	7.6%	118941	56.4%	210921	100.0%
01/04/2004	53805	25.5%	22159	10.5%	15995	7.6%	118941	56.4%	210921	100.0%
01/05/2004	53805	25.5%	22159	10.5%	15995	7.6%	118941	56.4%	210921	100.0%
01/06/2004	52954	25.1%	22481	10.7%	16048	7.6%	119428	56.6%	210911	100.0%
01/07/2004	51787	24.6%	22575	10.7%	16293	7.7%	120250	57.0%	210905	100.0%
01/08/2004	51056	24.2%	22697	10.8%	16511	7.8%	120624	57.2%	210888	100.0%
01/09/2004	49954	23.7%	22951	10.9%	16640	7.9%	121345	57.5%	210890	100.0%
01/10/2004	58732	26.7%	23084	10.5%	16687	7.6%	121634	55.3%	220137	100.0%
01/11/2004	58732	26.8%	23084	10.5%	16504	7.5%	120759	55.1%	219079	100.0%
01/12/2004	58732	26.8%	23084	10.5%	16504	7.5%	120759	55.1%	219079	100.0%
01/13/2004	58341	26.6%	23306	10.6%	16504	7.5%	120898	55.2%	219072	100.0%
01/14/2004	58264	26.6%	23343	10.7%	16538	7.5%	120927	55.2%	219072	100.0%
01/15/2004	58061	26.5%	23382	10.7%	16542	7.5%	121082	55.3%	219067	100.0%
01/16/2004	57359	26.2%	23442	10.7%	16691	7.6%	121573	55.5%	219065	100.0%
01/17/2004	56957	26.0%	23532	10.7%	16726	7.6%	121841	55.6%	219056	100.0%

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REPORT CATEGORY:	Summary/Management Report
REPORT MENU HIERARCHY AND FORMAT NAME:	REPORT ⇒SUMMARY/MANAGEMENT REPORTS ⇒ **PERFORMANCE STANDARD**
PRINTED REPORT TITLE:	Performance Standard
REPORT DESCRIPTION:	This report will be used to measure contractor compliance with the performance standard. The performance standard requires that no more than 10% of the sets remaining in *Open* status at the end of a month shall have load dates over 30 days old. The report shows the Reporting Month; Beginning Inventory; Receipts; Monthly Inventory; the total number of sets "Moved" during the reporting month; the total number of sets Moved within 30 days of set load dates; Ending Inventory; the total number of sets in Ending Inventory Over 30 Days old; the Percent Moved Within 30 Days; and the Percent Remaining Over 30 Days. The data is grouped by contract.

FIELD DESCRIPTIONS

Field Name	Definition
Reporting Month:	The month and year for which the statistics are applicable.
Beginning Inventory:	The total number of sets in *Open* status at the beginning of the reporting month.
Receipts:	The total number of new sets loaded or the number of sets which changed to *Open* status during the reporting month.
Monthly Inventory:	The sum of the Beginning Inventory and Receipts.
Moved:	The total number of sets moved for *Open* status to *Pending*, *Validate*, or *Closed* status during the reporting month.
Moved Within 30 Days:	Of those sets moved during the reporting month, the number moved within 30 days of their load date.
Ending Inventory:	The Monthly Inventory minus the number Moved. The result is the total number of remaining sets in *Open* status.
Ending Inventory Over 30 Days:	The total number of claim sets remaining in *Open* status with load dates over 30 days old.
% Moved In 30 Days:	Of those sets moved, the percentage moved within 30 days of their load date.
% Remaining Over 30 Days:	The percentage of claim sets remaining in *Open* status with load dates over 30 days old.

REPORT PARAMETER OPTIONS:	Users may customize the report by selecting: a single reporting month or a range of reporting months; one or all FIs; one, several or all regions within selected FIs.
REPORT NOTES:	The data used by this report format is set level data.

PERFORMANCE STANDARD

Date: 9/17/2007

Owner FI = 03

(Refer to report description in TRICARE Operations Manual for field definitions)

Owner Region = All

Per Period From 1/2004 To 05/2004

03 - Humana MHS

Undetermined Region

Reporting Month	Beginning Inventory	Receipts	Monthly Inventory	Moved	Moved Within 30 Days	Ending Inventory	Ending Inventory Over 30 Days	% Moved in 30 Days	**% Remaining Over 30 Days**
01/2004	1516	133	1649	352	28	1297	1181	8.0%	**91.1%**
02/2004	1297	70	1367	574	28	793	731	4.9%	**92.2%**
03/2004	793	115	908	688	44	220	131	6.4%	**59.5%**
04/2004	220	173	393	299	169	94	1	56.5	**1.1%**
05/2004	94	110	204	119	94	85	1	79.0%	**1.2%**

Region 3, 4

Reporting Month	Beginning Inventory	Receipts	Monthly Inventory	Moved	Moved Within 30 Days	Ending Inventory	Ending Inventory Over 30 Days	% Moved in 30 Days	**% Remaining Over 30 Days**
01/2004	53835	9353	63188	13693	929	49495	40960	6.8%	**82.8%**
02/2004	49495	7534	57029	22491	2030	34538	28906	9.0%	**83.7%**
03/2004	34538	8765	43303	28539	3603	14764	9308	12.6%	**63.0%**
04/2004	14764	10612	25376	18110	4061	7266	678	22.4%	**9.3%**
05/2004	7266	9941	17207	5957	1327	11250	2593	22.3%	**23.0%**

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REPORT CATEGORY:	Summary/Management Report
REPORT MENU HIERARCHY AND FORMAT NAME:	REPORT ⇒SUMMARY/MANAGEMENT REPORTS ⇒**DOLLAR TOTALS**
PRINTED REPORT TITLE:	Dollar Totals
REPORT DESCRIPTION:	This report summarizes the total dollars identified for recoupment and actually recouped, as well as the total allowed amount of the applicable adjustments by Regional contract. The report reflects the total dollars on the system at the time the report is run. The fields displayed on the report are: Owner FI; Region; Total Amount Identified For Recoupment; Total Amount Actually Recouped; and the Total Allowed Amount of the Associated Adjustments. The totals reflect only those sets in *Pending*, *Validate*, or *Closed* status.
REPORT PARAMETER OPTIONS:	Users may customize the report by selecting: All "Standard" parameters minus Claim Set Status and Claim Type (Adjustments, Set Owner Type, Match Type, Date Type, Set Range, FI, Region) plus Set Range, Set and Claim Level User Defined Codes, Responsible FI and Region.
REPORT NOTES:	The data used by this report format is set level data.

Status Codes = P or V or C
Adjust Type = All
Owner Type = All
Claim Type = All
Match Type = All
Set Number = All
Owner FI = All
Owner Region = All
Resp FI = All
Resp Region = All
Set User Codes = All
Claim User Codes = All
Enroll Codes = All

Date: 9/17/2007

DOLLAR TOTALS

50 - Acme Claims Processing

	Total Amount Identified For Recoupment	Total Amount Actually Recouped	Total Allowed Amount of the Associated Adjustments
Area 1	$2,000.00	$1,115.44	$1,115.44
Totals	$2,000.00	$1,115.44	$1,115.44

99 - Inactive Contractor

	Total Amount Identified For Recoupment	Total Amount Actually Recouped	Total Allowed Amount of the Associated Adjustments
Inactive - CA/HI 88C	$0.00	$0.00	$0.00
Totals	$0.00	$0.00	$0.00

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REPORT CATEGORY:	Summary/Management Report
REPORT MENU HIERARCHY AND FORMAT NAME:	REPORT ⇒SUMMARY/MANAGEMENT REPORTS ⇒**LOAD DATE REPORT**
PRINTED REPORT TITLE:	Initial Load Date Report
REPORT DESCRIPTION:	This report provides a listing of set initial load dates grouped by contract.
REPORT PARAMETER OPTIONS:	Users may customize the report by selecting: All "Standard" parameters minus Set Range (Claim Set Status, Adjustments, Set Owner Type, Claim Type, Match Type, Date Type, FI, Region).
REPORT NOTES:	The data used by this report format is set level data.

Status Code = All
Adjust Type = All
Owner Type = All
Match Type = All
Claim Type = All
Owner FI = All
Owner Region = All
Enroll Codes = All

Date: 9/17/2007

INITIAL LOAD DATE REPORT

50 - Acme Claims Processing

Undetermined Region	Initial Load Date	Number of Sets
	9/24/1996	110
	Region Totals	110
	FI Totals	110

51 - Claims 'R' Us

Area 51	Initial Load Date	Number of Sets
	9/24/1996	1
	Region Totals	1
	FI Totals	1

55 - East West Claims

Undetermined Region	Initial Load Date	Number of Sets
	9/24/1996	1
	Region Totals	1
	FI Totals	1

73 - HAL Systems Inc

Undetermined Region	Initial Load Date	Number of Sets
	9/24/1996	1
	Region Totals	1
	FI Totals	1

99 - Inactive Contractor

Inactive - CA/HI 93C	Initial Load Date	Number of Sets
	9/24/1996	1
	Region Totals	1

Inactive - CA/HI 88C	Initial Load Date	Number of Sets
	9/24/1996	1
	Region Totals	1
	FI Totals	2
	Grand Totals	115

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REPORT CATEGORY:	Summary/Management Report
REPORT MENU HIERARCHY AND FORMAT NAME:	REPORT ⇒SUMMARY/MANAGEMENT REPORTS ⇒**USER ACTIVITY DETAIL**
PRINTED REPORT TITLE:	User Activity Detail Report
REPORT DESCRIPTION:	This report provides a listing of transaction dates and times and associated User IDs grouped by set number. The report shows changes in Set Status; FI; User ID; Amount Identified For Recoupment; Amount Actually Recouped; and the Adjustment Amount.
REPORT PARAMETER OPTIONS:	Users may customize the report by selecting: Set Range, Transaction Dates, and User IDs.
REPORT NOTES:	The data used by this report format is set level data.

User ID = All

Date: 9/17/2007

USER ACTIVITY DETAIL REPORT

Transact Date = All

100 >= Set Number <= 110

Set #	Stat	FI	Region	Init Load Dt	Trans Date Time	User	ID'D Recoup Amt	Actual Recoup Amt	Adjusted Amt
101	O	59			4/14/1997 04:35PM	CLAIMADD	0.00	0.00	0.00
101	O	59			4/14/1997 04:35PM	CLAIMADD	0.00	0.00	0.00
101	O	99	Inactive - CA/HI 93C		4/14/1997 04:56PM	SYSTEM	0.00	0.00	0.00
101	C	99	Inactive - CA/HI 93C	4/14/1997	3/16/2004 01:13PM	REP	0.00	0.00	0.00

Set #	Stat	FI	Region	Init Load Dt	Trans Date Time	User	ID'D Recoup Amt	Actual Recoup Amt	Adjusted Amt
103	O	45			4/14/1997 04:35PM	CLAIMADD	0.00	0.00	0.00
103	O	45			4/14/1997 04:35PM	CLAIMADD	0.00	0.00	0.00
103	O	3F	Region 3, 4 Foreign		4/14/1997 04:57PM	SYSTEM	0.00	0.00	0.00
103	P	3F	Region 3, 4 Foreign		12/12/1997 08:36AM	WPSSTOL	158.03	158.03	0.00

Set #	Stat	FI	Region	Init Load Dt	Trans Date Time	User	ID'D Recoup Amt	Actual Recoup Amt	Adjusted Amt
107	O	53			4/14/1997 04:35PM	CLAIMADD	0.00	0.00	0.00
107	O	53			4/14/1997 04:35PM	CLAIMADD	0.00	0.00	0.00
107	O	99	Inactive - CA/HI 93C		4/14/1997 04:59PM	SYSTEM	0.00	0.00	0.00
107	C	99	Inactive - CA/HI 93C	4/14/1997	3/16/2004 01:15PM	REP	0.00	0.00	0.00

Set #	Stat	FI	Region	Init Load Dt	Trans Date Time	User	ID'D Recoup Amt	Actual Recoup Amt	Adjusted Amt
109	O	45			4/14/1997 04:35PM	CLAIMADD	0.00	0.00	0.00
109	O	45			4/14/1997 04:35PM	CLAIMADD	0.00	0.00	0.00
109	O	45			4/14/1997 04:35PM	CLAIMADD	0.00	0.00	0.00
109	O	3F	Region 3, 4 Foreign		4/14/1997 04:57PM	SYSTEM	0.00	0.00	0.00
109	P	3F	Region 3, 4 Foreign		12/12/1997 08:38AM	WPSSTOL	1585.15	1585.15	0.00

Set #	Stat	FI	Region	Init Load Dt	Trans Date Time	User	ID'D Recoup Amt	Actual Recoup Amt	Adjusted Amt
110	O	53			4/14/1997 04:35PM	CLAIMADD	0.00	0.00	0.00
110	O	53			4/14/1997 04:35PM	CLAIMADD	0.00	0.00	0.00
110	O	53			4/14/1997 04:35PM	CLAIMADD	0.00	0.00	0.00
110	O	99	Inactive - CA/HI 93C		4/14/1997 04:59PM	SYSTEM	0.00	0.00	0.00
110	C	99	Inactive - CA/HI 93C	4/14/1997	3/16/2004 01:15PM	REP	0.00	0.00	0.00

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REPORT CATEGORY:	Summary/Management Report
REPORT MENU HIERARCHY AND FORMAT NAME:	REPORT ⇒SUMMARY/MANAGEMENT REPORTS ⇒**USER ACTIVITY SUMMARY**
PRINTED REPORT TITLE:	User Activity Summary Report
REPORT DESCRIPTION:	This report provides a summary of the transactions performed by individual user ID. The report provides the total number of updates performed by a USER ID, the total number of sets updated by that USER ID, and the net change in status in the following categories: sets moved from *Open* to *Pending* and *Pending* to *Open*; *Open* to *Validate* and *Validate* to *Open*; *Open* to *Closed* and *Closed* to *Open*; *Pending* to *Closed* and *Closed* to *Pending*; *Pending* to *Validate* and *Validate* to *Pending*; and *Validate* to *Closed* and *Closed* to *Validate*. This report can provide management with a summary view of user activity by individual USER ID.
REPORT PARAMETER OPTIONS:	Users may customize the report by selecting: Set Range, Transaction Dates, and User IDs.
REPORT NOTES:	The data used by this report format is set level data.

Date: 9/17/2007

User ID = All

200>= Set Number <= 300

USER ACTIVITY SUMMARY REPORT

Transact Date = All

USER	TOTAL UPDATES	SETS UPDATED	NET CHANGE IN STATUS FROM:					
			O-P	O-V	O-C	P-C	P-V	V-C
cnolan	1	1	0	0	0	0	-1	0
UNIGREAT	1	1	1	0	0	0	0	0
PGBSHAR	1	1	-1	0	0	0	0	0
PGBTURN	1	1	0	1	0	0	0	0
pprsqt09	2	2	-1	0	0	0	0	1
UNIFIELD	6	5	5	0	0	0	0	0
UNINEWM	4	3	0	0	0	0	0	0
UNIPEARS	1	1	0	0	0	0	0	0
HMSPOOLE	1	1	1	0	0	0	0	0
HMSCOBB	1	1	0	0	0	0	1	0
PGBMCAL	1	1	1	0	0	0	0	0
EIDRHHA	1	1	0	0	0	0	0	0
jrusso	2	1	0	0	0	1	0	0
WPSHUNER	1	1	1	0	0	0	0	0
PGBSMIT	2	2	2	0	0	0	0	0
PGBTHOM	1	1	1	0	0	0	0	0
PGBBOYD	1	1	0	0	0	0	0	0
WPSNAV	1	1	1	0	0	0	0	0
PGBMCCA	3	1	0	0	0	0	0	0
Totals	30	27	11	1	0	1	0	1

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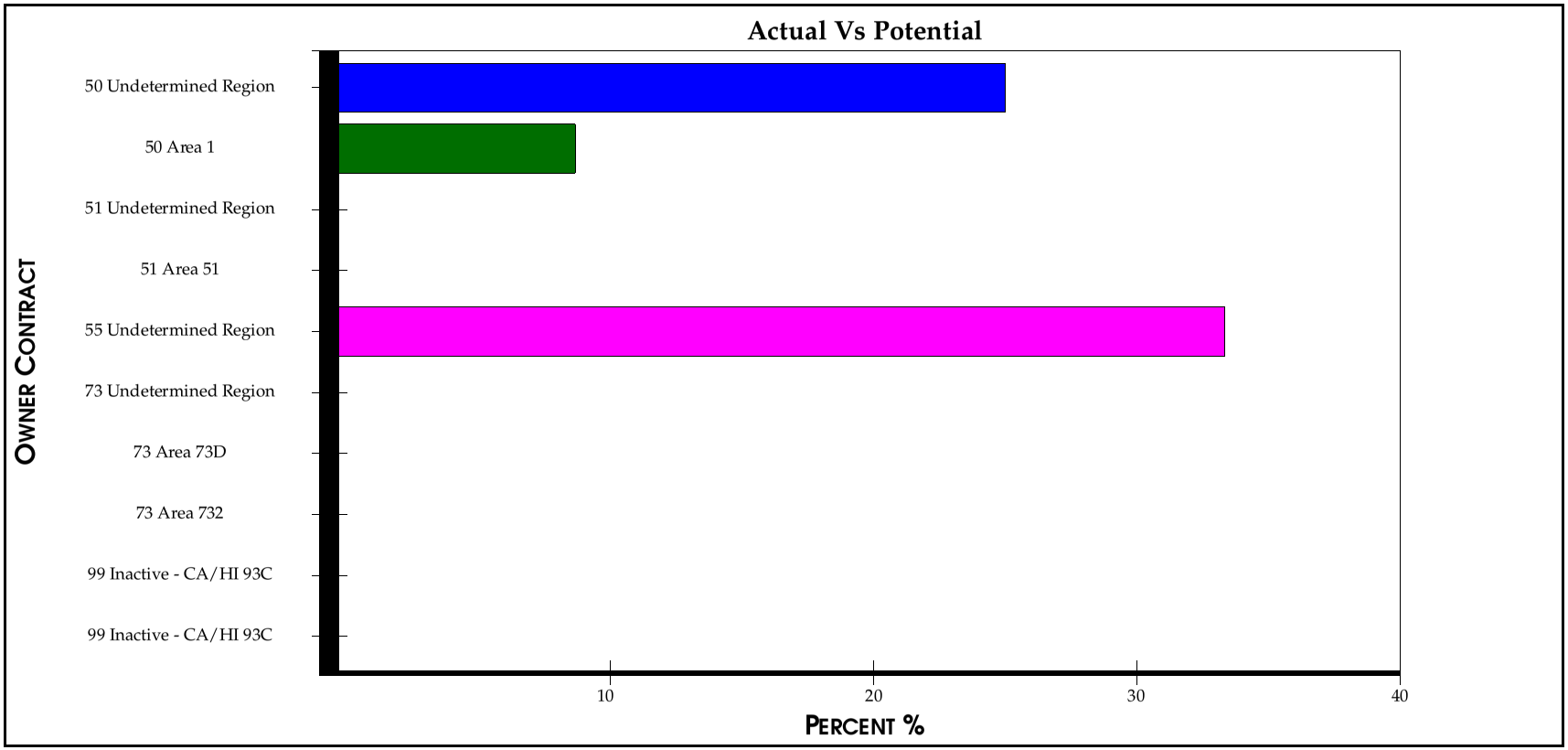
REPORT CATEGORY:	Graphs
REPORT MENU HIERARCHY AND FORMAT NAME:	REPORT ⇒GRAPHS ⇒**ACTUAL VS. POTENTIAL**
PRINTED REPORT TITLE:	Total Actual Duplicates as a Percentage of Total Potential Duplicates
REPORT DESCRIPTION:	This report provides the user with a graph which shows the total number of distinct actual duplicate claims ('Y' Duplicate Flag values in *Pending*, *Validate*, or *Closed* status) as a percentage of the total number of distinct potential duplicates in the system (all non-base claims). The data displayed is grouped by region.
REPORT PARAMETER OPTIONS:	Users may customize the report by selecting: All "Standard" parameters minus Claim Set Status and Set Range (Adjustments, Set Owner Type, Claim Type, Match Type, Date Type, FI, Region).
REPORT NOTES:	The data used by this report format is set level data. If a claim appears in more than one set and the sets are owned by different regions, the claim will be counted once for each region.

Adjust Type = All
Match Type = All
Owner Type = All
Claim Type = All
Owner FI = All
Owner Region = All

Date: 9/17/2007

TOTAL ACTUAL DUPLICATES AS A PERCENTAGE OF TOTAL POTENTIAL DUPLICATES



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REPORT CATEGORY:	Graphs
REPORT MENU HIERARCHY AND FORMAT NAME:	REPORT ⇒GRAPHS ⇒**USER ACTIVITY SUMMARY**
PRINTED REPORT TITLE:	User Activity Summary
REPORT DESCRIPTION:	This report provides the user with a graphical representation of the data in the User Activity Detail Report. The graph provides a summary of the transactions performed by individual user ID. The report provides the total number of updates performed by a USER ID, the total number of sets updated by that USER ID, and the net change in status in the following categories: sets moved from *Open* to *Pending* and *Pending* to *Open*; *Open* to *Validate* and *Validate* to *Open*; *Open* to *Closed* and *Closed* to *Open*; *Pending* to *Closed* and *Closed* to *Pending*; *Pending* to *Validate* and *Validate* to *Pending*; and *Validate* to *Closed* and *Closed* to *Validate*. This report can provide management with a summary view of user activity by individual USER ID.
REPORT PARAMETER OPTIONS:	Users may customize the report by selecting: Set Range, Transaction Dates, and User IDs.
REPORT NOTES:	The data used by this report format is set level data. This report is best viewed on screen or printed to a color printer.

Date: 9/17/2007

User ID = All

USER ACTIVITY SUMMARY LIST REPORT

200>= Set Number <= 300

Transact Date = All

USER	TOTAL UPDATES	SETS UPDATED	NET CHANGE IN STATUS FROM:						CHART GROUP
			O-P	O-V	O-C	P-C	P-V	V-C	
PGBSHAR	1	1	-1	0	0	0	0	0	1
PGBTURN	1	1	0	1	0	0	0	0	
pprsqt09	2	2	-1	0	0	0	0	1	
UNIFIELD	6	5	5	0	0	0	0	0	
UNINEWM	4	3	0	0	0	0	0	0	
UNIPEARS	1	1	0	0	0	0	0	0	
HMSPOOLE	1	1	1	0	0	0	0	0	
HMSCOBB	1	1	0	0	0	0	1	0	
cnolan	1	1	0	0	0	0	-1	0	
UNIGREAT	1	1	1	0	0	0	0	0	
jrusso	2	1	0	0	0	1	0	0	2
WPSHUNER	1	1	1	0	0	0	0	0	
PGBSMIT	2	2	2	0	0	0	0	0	
PGBTHOM	1	1	1	0	0	0	0	0	
PGBBOYD	1	1	0	0	0	0	0	0	
PGBMCCA	3	1	0	0	0	0	0	0	
PGBMCAL	1	1	1	0	0	0	0	0	
EIDRHHA	1	1	0	0	0	0	0	0	
WPSNATV	1	1	1	0	0	0	0	0	
Totals	32	27	11	1	0	1	0	1	

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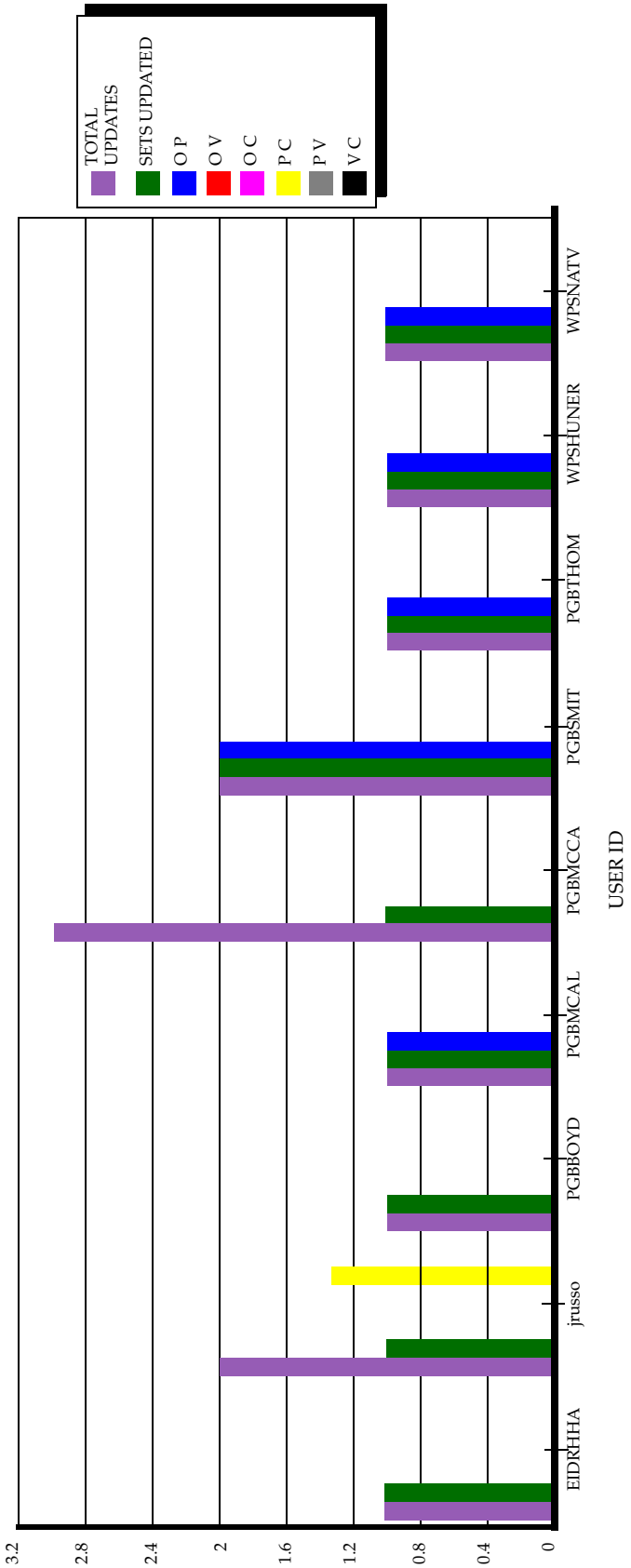
User ID = All

200 => Set Number <= 300

Chart Group = 2

Date: 9/17/2007

USER ACTIVITY SUMMARY GRAPH REPORT



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Page 1

DCUTLADJ.TXT	START	LENGTH	
Set Number	001	11	key
HCSR ICN	012	14	key
HCSR Time	026	6	key
HCSR Suffix	032	1	key
Occurrence Count	033	6	key
Adjustment ID	*039*	*20*	
Adjust Date	*059*	22	
Adjust Indicator	*081*	1	
Amt Allowed CPT-4 Code	*082*	20	
CPT-4 Code	*102*	5	
Non-Inst Care Begin Dt	*107*	22	
Responsible FI	*129*	2	
Cycle Number	*131*	6	

DCUTLZTN.TXT	START	LENGTH	
Set Number	001	11	key
HCSR ICN	012	14	key
HCSR Time	026	6	key
HCSR Suffix	032	1	key
Occurrence Count	033	6	key
Line Item Match Type	039	1	
CPT-4 Code	040	5	
Place of Service	045	2	
Type of Service	047	2	
Non-Inst Care Begin Dt	049	22	
Non-Inst Care Begin Dt	071	22	
Amt Allowed CPT-4 Code	093	20	
Amt Billed CPT-4 Code	113	20	
Pricing Code	133	2	
CPT-4 Modifier 1	*135*	*2*	
CPT-4 Modifier 2	*137*	*2*	

DCSETCMT.TXT	START	LENGTH	
Set Number	001	11	key
Comment Line Type	012	1	key
Comment Line Sequence #	013	6	key
Comment Line Text	019	255	

DCSETLOG.TXT	START	LENGTH	
Set Number	001	11	key
Transaction Date	012	22	key
User Id	034	8	
Set Status	042	1	
Amt Id Recoup	043	20	
Amt Actual Recoup	063	20	
Owner FI	083	2	
Adjust Amt	085	20	
Contract Number	105	7	
Current Load Date	112	22	
Initial Load Date	134	22	

DCCMNT.TXT	START	LENGTH	
Set Number	001	11	key
HCSR ICN	012	14	key
HCSR Time	026	6	key
HCSR Suffix	032	1	key
Comment Line Text	033	255	

SETUSR.TXT	START	LENGTH	
Owner FI	001	2	key
Contract Number	003	7	key
Set Level User Defined Code	010	2	key
User Defined Text	012	30	
Active/Inactive Indicator	042	1	

DCCLMUSR.TXT	START	LENGTH	
Owner FI	001	2	key
Contract Number	003	7	key
Set Level User Defined Code	010	2	key
User Defined Text	012	30	
Active/Inactive Indicator	042	1	

DCCOUNT.TXT	START	LENGTH	
As of Date	001	22	key
Owner FI	023	2	key
Contract Number	025	7	key
Open Status Number	032	11	
Pending Status Number	43	11	
Closed Status Number	54	11	
Validate Status Number	65	11	

DCCONTRACT.TXT	START	LENGTH	
Contract Number	001	7	key
Contract Description	*008*	20	
FI Number	*001*	*2*	

DCSFI.TXT	START	LENGTH	
FI/Contractor Number	001	2	key
Abbreviation	003	8	
FI/Contractor	011	60	

DCSREASON.TXT	START	LENGTH	
Reason Code	*001*	4	key
Reason	*005*	60	
Explain Code	*065*	1	
Display Key	*001*	*1*	

CHAPTER 10

TRICARE DUPLICATE CLAIMS SYSTEM - TED VERSION

SECTION	SUBJECT
1	**OVERVIEW**
	1.0. Preface
	2.0. Definition Of A Duplicate Claim Payment
	3.0. Development Of The System
	4.0. Functional Capabilities Of The *DCS*
	5.0. System Design
	FIGURE 10-1-1 System Platforms
	6.0. System Functions
2	**QUICK START INSTRUCTIONS**
	1.0. Entering And Exiting The *DCS*
	FIGURE 10-2-1 *Common Access Card (CAC) Screen*
	FIGURE 10-2-2 *Privacy Statement Screen*
	FIGURE 10-2-3 *User ID/Password Screen*
	FIGURE 10-2-4 *PEPR Portal Screen*
	FIGURE 10-2-5 *DCS System Screen*
	FIGURE 10-2-6 *TRICARE DCS* Access Screen
	FIGURE 10-2-7 *Set Screen*
	2.0. Setting A View
	FIGURE 10-2-8 *Set A View Screen*
	FIGURE 10-2-9 *Select Data View Screen*
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	4.0. Identifying A Duplicate Claim
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OVERVIEW

NOTE: *The TRICARE Management Activity (*TMA*) has* develop*ed* a web-based version of the *TRICARE Duplicate Claims S*ystem *(DCS)* that run*s* on the Internet/*Nonsecure Internet Protocol Router Network (*NIPRNET*)*. The functionality of the web version *mimics the functionality of* the 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* the 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 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 TRICARE Encounter Data (TED) database. The system also generates operational and management reports.The main difference between the Health Care Service Record (HCSR) version of the DCS and the TED version is the way non-institutional line items are handled. The TED version gives the user the capability to identify actual duplicates at the line item level. The TED record contains line item level *Government* paid amounts where the HCSR contained only line item allowed amounts. In the TED version, adjustments will reflect *Government* paid amounts rather than allowed amounts. This difference is reflected in the TED version's resolve logic. To resolve a *non-institutional* set in the TED version, the adjustment amount must now equal the actual recoupment amount. In the HCSR version*, for both institutional and non-institutional sets,* the adjustment allowed amount*s have* to be equal to or greater than the actual recoupment amount*s, for TED institutional sets the adjustment amounts must be equal to or greater than the actual recoupment amounts*. Also, the TED record does away with payment record suffixes. In the HCSR version, claims are uniquely identified by *Internal Control Number (*ICN*)*, Suffix*,* and Time Stamp. In the TED version, a unique claim is identified by ICN and Time Stamp only. Finally, the Line Item Screen in the TED version contains a horizontal scroll bar that permits the user to see additional data elements that *are* not available in the HCSR version.

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 TEDs.

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 and lower case letters and bold type (e.g., **Dupe?** 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 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 adjustment Government paid amount 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 TEDs, 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?

It must be noted that "claims" displayed in the *DCS* are *in fact* TED records *the contractors submitted*. The Government assumes that the TED 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 TED database. They are seeing what appears to the Government to be duplicate payments. Users might think of TED records as entries in the Government's checkbook. When a pair of TED 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 TED record on the TED 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 TED records displayed in the DCS must be flagged as actual duplicates, and must be corrected through adjustments and cancellations to remove the duplicate conditions from the TED database.

2.1. *TED Dupes*

The DCS identifies two kinds of duplicate TEDs:

- *Those that represent actual overpayments (where two or more payments were actually made and recoupments must be initiated to recover the erroneous payments); and*
- *Those that were submitted but no actual payments were made (and therefore no recoupment actions need to be initiated).*

It is this second kind of duplicate TED that we refer to as a "TED Dupe." TED Dupes most often occur when claims are processed but for some reason are pulled before the checks are actually sent and then re-processed under different claim numbers. If the original claims processed to the point that TEDs were created, submitted, and accepted by TMA, and not subsequently cancelled, the TEDs representing the reprocessed claims (with different claim numbers) will "dupe out" with the original, uncancelled, TEDs residing on the TED database. To the Government, all of those TEDs look like actual payments were made. There is no way for the Government to look at a TED and know that a check was not really issued and sent. They all look as though payments were made.

When a contractor, while researching potential duplicate claims in their system, discovers that a claim was not really paid but is appearing in the DCS as though it had been, the contractor may be tempted to flag the record in the DCS as not being an actual duplicate. This would be incorrect. Since the TEDs in the DCS look to the Government as if actual payment were made, the contractor must flag the TEDs as actual duplicates regardless of whether actual payments were made and recoupments initiated or not. Where a TED appearing in the DCS did not involve an actual payment, it still must be flagged as an actual duplicate and a cancellation submitted even though no recoupment was initiated and no refund received (remember, no check was actually sent) in order to correctly resolve this set. The cancellation will remove the duplicate condition on the TED database.

*To resolve a set involving a TED Dupe, the contractor should flag the record as a 'Y' Dupe and populate the **ID Recoup Amount** with the Government paid amount. The contractor should then enter Government paid amount in the **Actual Recoup Amount** field and request that a cancellation TED be created and submitted to TMA. Once TMA receives the cancellation TED record and applies it to the TED database, the cancellation will appear in the set in the DCS as an adjustment. The contractor then needs to flag the cancellation with a 'Y' which will cause the DCS to populate the **Adjust Amount** field with the **Government Paid Amount**. Now the **Actual Recoup Amount** equals the **ID Recoup Amount** and the **Adjusted Amount** equals the **Actual Recoup Amount** and the set can be closed.*

Where there are more than two TEDs in the set, resolution of the set may be more complicated but the important point to remember is that TED Dupes are Actual Dupes in the DCS and must be treated as if an actual duplicate payment had been made.

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 TED adjustments to correct duplicate conditions in the TED 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, TED 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 TED 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

3.2.1. The system was designed to meet the following objectives:

- To create a user-friendly, cost-effective application using *web-based* technology;
- To preserve TED data integrity and display only those potential duplicate claims records applicable to each contractor;
- To provide as much data as possible to assist contractors in their efforts to identify actual duplicate payments;
- 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;

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

- To automate and simplify methods for contractors to report their determinations as to whether the identified potential duplicate TEDs represent actual duplicate payments and, if they do, to report the corresponding amounts expected to be recouped;

- To automate and simplify methods for contractors to report actual recoupment amounts and provide a mechanism for verifying that TED adjustments/ cancellations were submitted and accepted, thereby correcting the duplicate condition in the TED database;

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

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

3.2.2. 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 TED-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 TED 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 TED database by submitting an adjustment/ cancellation TED. When the TED 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 TED database by flagging the adjustment transaction (i.e., by entering 'Y' in the **TED 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 10-4-1.*) 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 TED Data To Create And Maintain The Duplicate Claims Databases

Using the duplicate claims detection criteria, the *DCS* identifies potential duplicate claims from TEDs residing in the TED database. *Copies of t*hese claims are extracted from the TED database. At the same time, data elements and values required for system operation are added and the *data is* loaded to *tables on* a TMA *DB2* Server. These tables comprise the Duplicate Claims *d*atabases. TED 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

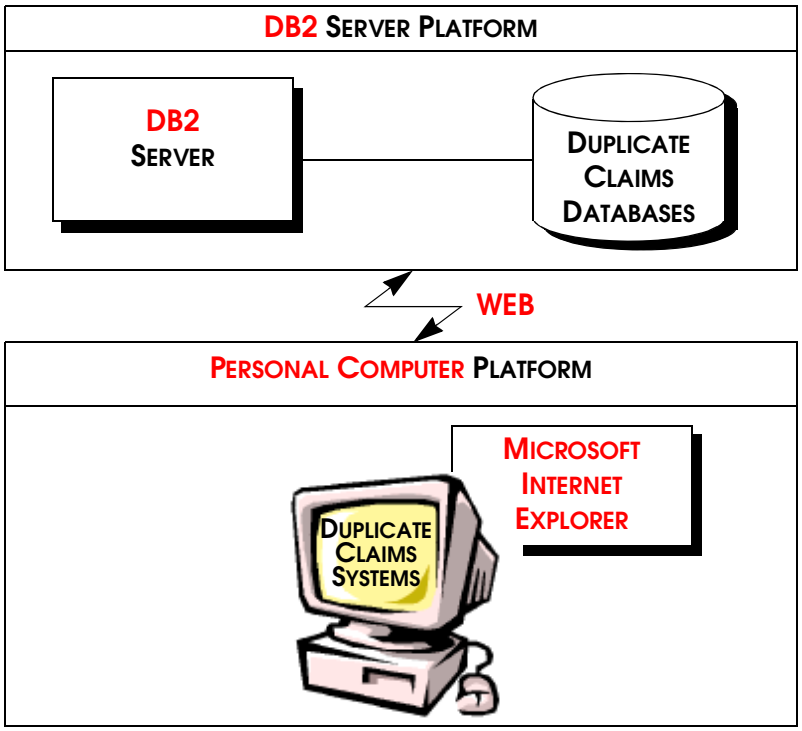
The PC platform is composed of PCs *using MSIE, Version 5.5, 6.0, or 7.0 or as directed by the Government. These PCs may be stand-alone or networked computers. The PCs must have Internet access.*

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 10-1-1, 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* communications. See the TSM, Chapter 1 for *the* telecommunications requirements *for accessing the TRICARE DCS*.

FIGURE 10-1-1 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, *Patient ID*, or ICN; designating a claim as either an actual duplicate or a non-duplicate; entering identified and actual recoupment amounts; linking TED 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 TED data on the *DB2 Server* to identify and extract potential duplicate claims and associated TED 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 *Purchased Care* 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 TED 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 (or line item) 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 TED adjustment and link this adjustment to the actual duplicate institutional claim or non-institutional line item after the adjustment has been processed by the TED 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 TED 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;

6.2.8. Appending new TED claims to existing sets*; and*

6.2.9. *Temporarily disabling sets involving provisionally accepted TEDs.*

QUICK START INSTRUCTIONS

This section provides instructions for using the Duplicate Claims System (DCS). The following components are necessary to access the system:

- A DCS User ID and password
- Microsoft® Internet Explorer (MSIE), Version 5.5, 6.0, or 7.0 or as directed by the Government
- The Government's DCS web address

Quick Start Instructions assumes familiarity with the personal computer (PC) environment, Windows®, and TRICARE Encounter Data (TED) records. Instructions are presented in the following order:

- Entering and Exiting the System
- Setting a View
- Looking for a Claim Set, Internal Control Number (ICN), or Patient ID
- Identifying a Duplicate Claim
- Resolving a Duplicate Claim Set
- Working with Multi-Contractor Sets
- Creating a Report
- Changing a Password
- Using the HELP System

The DCS verifies that the User ID and password are authorized. This process also identifies the user's organization and determines which claim records from the Duplicate Claims database can be viewed. For example, if the user is associated with Contractor 1, they will have access to Contractor 1 data only. The system uses an **Owner FI** field for each claim set to assign ownership of each set to a specific contractor.

1.0. ENTERING AND EXITING THE DCS

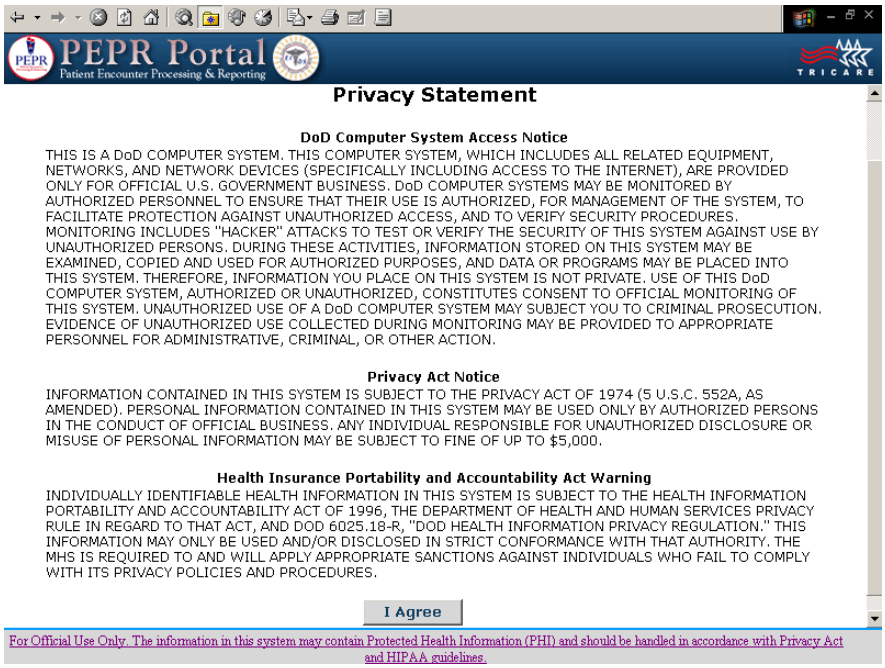
1.1. To access the DCS, start up the MSIE browser. Go to the DCS web address: https://peprsite.csd.disa.mil/pepr/pepr/.

1.2. *The COMMON ACCESS CARD (CAC) SCREEN (Figure 10-2-1) will be displayed. Until the Common Access Card (CAC) process has been implemented, click on the "If you don't have a CAC, click here" option.*

FIGURE 10-2-1 COMMON ACCESS CARD (CAC) SCREEN

1.3. *The PRIVACY STATEMENT SCREEN in the Patient Encounter Processing and Reporting (PEPR) Portal (Figure 10-2-2) will be displayed. Read it and then click the* ***I AGREE*** *button.*

FIGURE 10-2-2 PRIVACY STATEMENT SCREEN

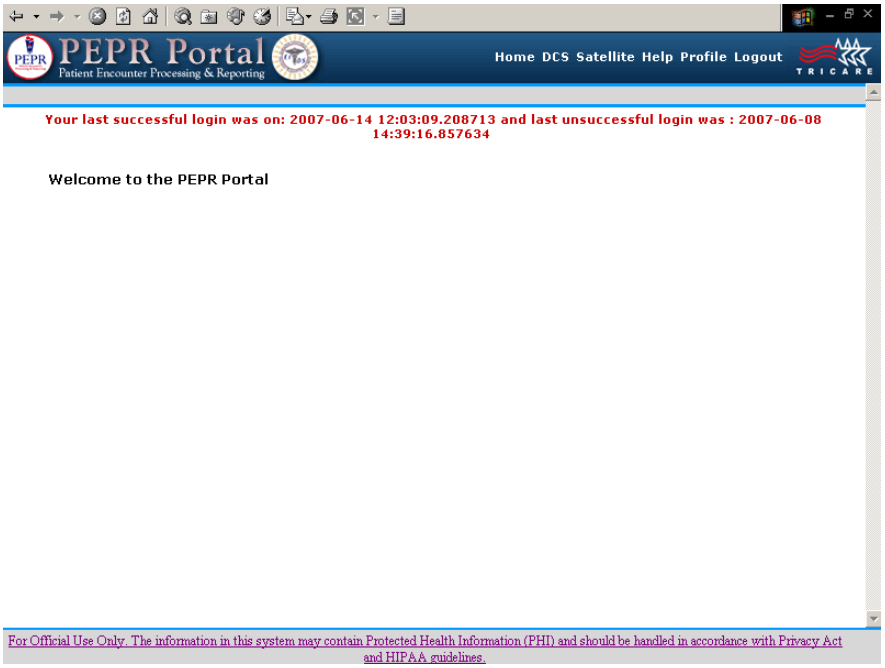


1.4. *The user will then be prompted to enter their User ID and password (Figure 10-2-3). (If the User ID and password are not accepted by the system, call the* ***MHS Help Desk*** *at* ***1-800-600-9332****.)*

FIGURE 10-2-3 USER ID/PASSWORD SCREEN

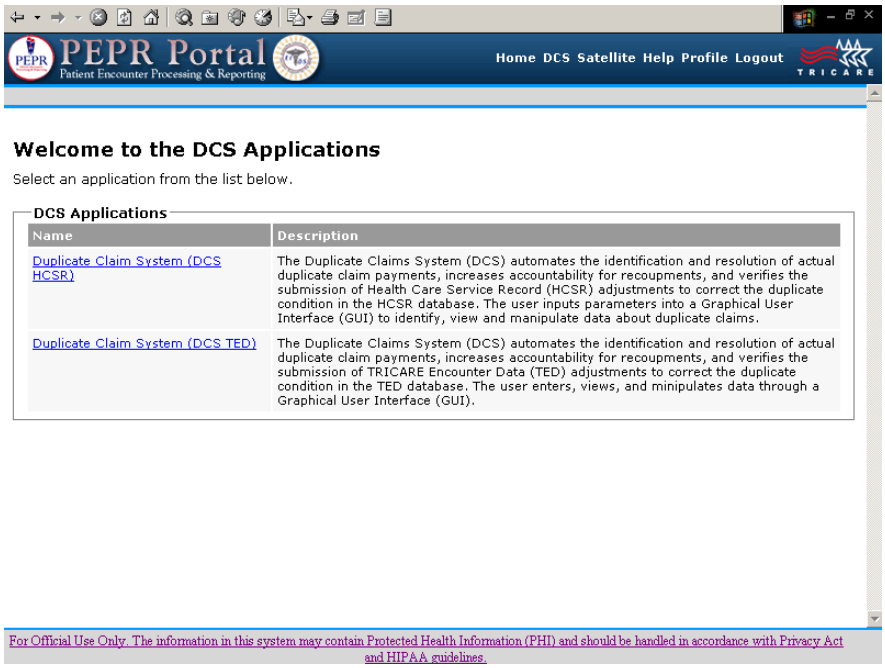
1.5. *The PEPR PORTAL SCREEN (Figure 10-2-4) will be displayed. Click on the* ***DCS*** *link on the PEPR Portal Toolbar (in the upper right side of the screen).*

FIGURE 10-2-4 PEPR PORTAL SCREEN



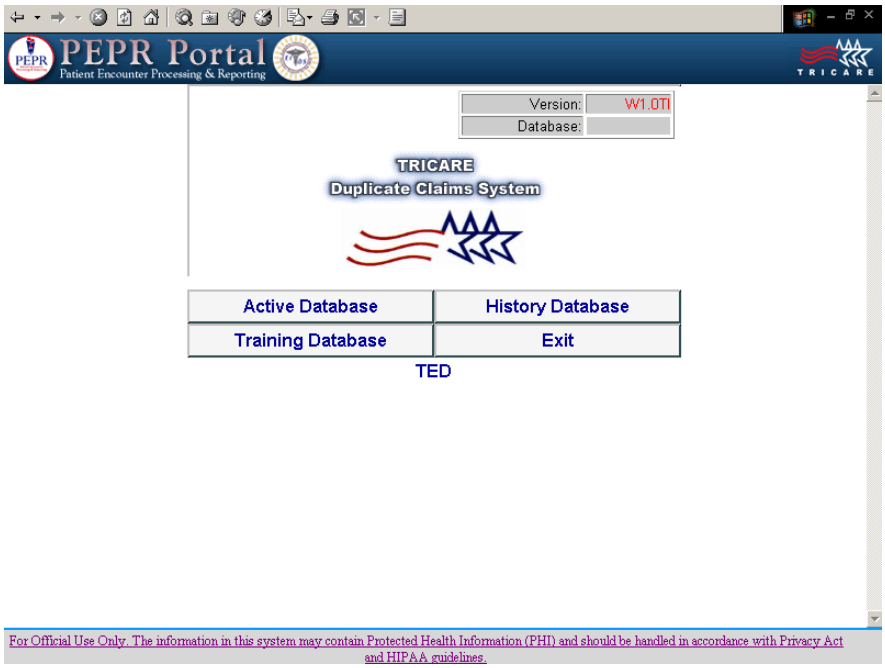
1.6. *The DCS SYSTEM SCREEN is displayed (Figure 10-2-5). Click on the* ***DCS*** *link.*

FIGURE 10-2-5 DCS SYSTEM SCREEN



1.7. The TRICARE *DCS* ACCESS SCREEN *(Figure 10-2-6) will be displayed*. Th*is screen* provides the option*s* of clicking on the **ACTIVE DATABASE** *or* **HISTORY DATABASE** button to *access* the *production DCS*, clicking on the **TRAINING** button to *access* the system using *the* training database, or clicking on the **EXIT** button to go back to *the PEPR Portal*.

FIGURE 10-2-6 TRICARE DCS ACCESS SCREEN



1.8. *By* clicking on the **ACTIVE DATABASE** or **HISTORY DATABASE** button*(s)*, a box with the message: "**Accessing Database. Working... Please wait...**" *will be displayed.* When access has been *achieved*, the SET SCREEN will appear *with* the **Set** tab active *(see Figure 10-2-7*).

FIGURE 10-2-7 SET SCREEN

1.9. To exit the *DCS*, click on **F**ile in the menu bar and click on **E**xit to return to the ACCESS SCREEN. *The user* can *then* click the **EXIT** button to return to *the PEPR PORTAL DCS SCREEN*. *Then click on* ***Logout*** *on the PEPR Portal Toolbar in the upper right section of the screen.*

1.10. To access the training database, click on the **TRAINING** ***DATABASE*** button on the ACCESS SCREEN.

1.11. *If the user elected to access the* ***ACTIVE DATABASE****,* the first set associated with *the* FI/ Contractor number *will be displayed*. *The user* may move within this set to the CLAIM DETAIL SCREEN or the LINE ITEM DETAIL SCREEN (if the set is a non-institutional set) by clicking on the **Detail** or **Line Item** *t*ab. *The user* may also view the ADJUSTMENT SCREEN if there is an **Adjustment** *t*ab indicating that an adjustment has been processed for one of the claims in the set. (The **Adjustment** *t*ab will only appear when a TED adjustment associated with the set has been submitted and accepted and has been loaded to the DCS.)

1.12. *The user* can use the Video Cassette Recorder (**VCR**) buttons at the bottom of the screen to move to the next set (>), the previous set (<), the first set (|<) or the last set (>|). *The user* can also move to a particular set by clicking on the # button

2.0. SETTING A VIEW

2.1. At any time, *the user* can click the View function on the menu bar to limit *the* view to certain categories of claim sets *(see Figure 10-2-8)*. The *SELECT DATA VIEW SCREEN*, as shown in *Figure 10-2-9*, allows *the user* to specify a subset of claim sets to view. *The user* can select a subset of claim sets by:

- Status code.
- Institutional or non-institutional sets.
- Sets with or without adjustments.
- Single contractor sets or multi-contractor sets.
- Claim match criteria, e.g., exact match, date overlap, CPT-4 code match, *etc*.
- Sets within a date range for processed to completion *(PTC)* date, initial load date, current load date, or last update date.
- Sets belonging to a specific region or a specific contractor.
- *Only sets with the specified enrollment codes.*
- *Sets with or without provisional claims.*
- Other parameters as available.

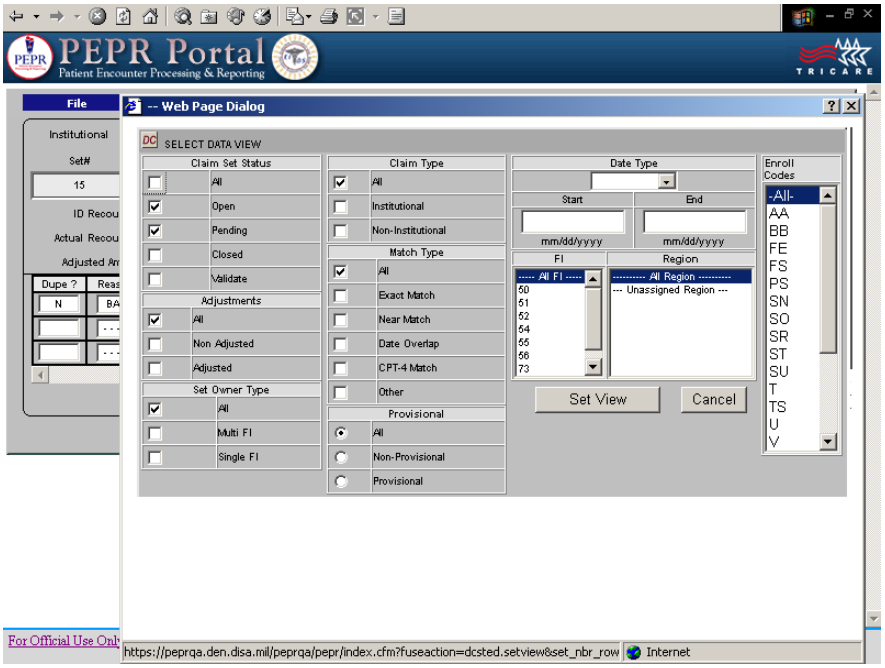
2.2. Sets may be selected by combining various View options. For example, *the user* may request all claim sets with an *Open* status for *the West* Region that meet the exact match criteria.

FIGURE 10-2-8 *SET A VIEW SCREEN*

2.3. When *the user* uses the View function, the system will remind *the user* that *a* restricted view of claim sets *is being* displayed *by* "**A View is Set!**" *message* on the screen. The View function also allows *the user* to "Clear a View" and return to full access of all *the user's* claim sets. If *the user* views *the* claim sets by status, *the user* can view *Open* sets to see the sets that

have not been researched enough to determine if a duplicate condition exists. Or *the user* can view *Pending* sets to see the sets that have been researched enough to determine that a duplicate payment was made and recoupment is pending. *The user* can *also* view sets *that are in Closed* or *Validate status*. See *Section 4, paragraph 3.0.,* for additional details about claim set status.

FIGURE 10-2-9 *SELECT DATA VIEW SCREEN*



3.0. LOOKING FOR A SPECIFIC SET AND MODIFYING SETS

3.1. At any time, *the user* can click the **L**ocate function on the menu bar to view a specific set by Set Number, ICN, *Sponsor ID,* or *Patient ID*. Upon selection of one of these locate parameters, the system displays the claim set matching the *selected parameters*. If an ICN or *Patient ID* was entered, *the user* can go back to the **L**ocate function and see if other sets match the ICN, *Sponsor ID,* or *Patient ID*. If they do, the Locate **N**ext and/or Locate **P**revious options are displayed. If a previous or next option is not relevant to the ICN, *Sponsor ID,* or *Patient ID*, these choices are "grayed out" and not available to *the user*.

3.2. If a claim appears in more than one claim set, the ICN will be displayed in white characters. *The user* can double-click on the white ICN to view the set in which this same claim appears. *When the user double-clicks on the white ICN in the "next" set, the system* will prompt *the user* to move to the "Next" or "Previous" set, as appropriate.

3.3. A shortcut to locating a specific set by set number is provided as a **VCR** button at the bottom of the screen (#). To locate a specific set by it's Set Number, click on the # button, enter the number in the pop up window that appears and click on *the* **OK** *button*.

3.4. In addition to locating a specific set, *the user* may use the **M**odify function to change the **Owner FI** field of a multi-contractor claim set. (See *Section 6,* for more information about

how and when *the user* might want to change the **Owner FI** field.) The **M**odify function also allows *the user* to apply the correct region to a set which has been transferred to *the user*.

3.5. The choices available in the **M**odify function maintain data integrity by allowing *the user* to select only those choices that are appropriate to the situation. In other words, the choices available to *the user when* changing the **Owner FI** of a set include only those **Responsible FI**s *associated with* the claims in that set.

3.6. The **M**odify function also has a Government option available to a limited number of *the TRICARE Management Activity (*TMA*)* users who are authorized to change the status of sets. The system-assigned status of a set will only be overridden by TMA in consult with the applicable contractor.

4.0. IDENTIFYING A DUPLICATE CLAIM

When view*ing* a claim set, *the user* should understand that every claim set contains potential duplicate claims, i.e., two or more payments made for *the same* services for the same beneficiary on the same dates of service. Refer to *Section 3, to* see the criteria used to select potential duplicate claims. *Prior to the implementation of the National Provider Identifier (NPI), t*he type of match criteria used to select potential duplicate claims ranges from an "Exact" match in which 12 fields are the same, to an "Other" match in which *three, four, or* five fields are the same*, depending on whether the set involves institutional or non-institutional claims*. *Upon the implementation of the NPI, an "Exact" match will require 14 fields to be the same, and the "Other" match will require three, four, or five fields to be the same.*

The user can view these fields and others in the CLAIM DETAIL SCREEN and LINE ITEM DETAIL SCREEN (non-institutional claims only) *while* research*ing the claims in the set*. Note that institutional claims are matched at the claim level and non-institutional claims are matched at the line item level. *The user* can print out the data as they appear on these screens by accessing the **F**ile function on the menu bar and *selecting* **Print**. *The user* will need to conduct *the* research on *the user's* proprietary claims processing system and pull claim copies, when necessary to comply with other contract requirements (e.g., duplicate prevention requirements, recoupments, etc.), to determine if an actual duplicate payment was made.

5.0. RESOLVING A DUPLICATE CLAIM SET

To resolve a claim set, *the user* must:

- *C*onduct research
- *D*etermine the amount of overpayment, if any
- *I*nitiate recoupment action, if required
- *R*ecord actual refunds/offsets received, if any
- *S*ubmit TED adjustments, where required and
- *A*pply any TED adjustments loaded to the DCS.

5.1. Steps Of Resolution

To resolve a claim set, *the user* must enter data in at least two fields for sets involving no duplicate overpayments and five fields for sets containing actual duplicate overpayments.

(*The user* may also enter data into three additional, optional fields if the Managed Care Support Contractor *(MCSC)/TRICARE Dual Eligible Fiscal Intermediary Contractor (TDEFIC)* finds this optional data valuable.)

NOTE: *The user* may be prompted to type in an explanation for the data *that was* entered. This is explained below.

5.1.1. On the CLAIM SET SCREEN, *the user* may enter a 'Y' in the **Dupe?** field of an institutional claim to identify it as a duplicate payment or enter a 'N' in the **Dupe?** field of an institutional claim to identify it as a non-duplicate payment. For a non-institutional claim, a 'Y' or an 'N' may be entered in the **Dupe?** field on the CLAIM SET SCREEN or in the **Dupe?** field for each individual line item on the LINE ITEM SCREEN. If a 'Y' *was entered* on the CLAIM SET SCREEN, the system will automatically enter a 'Y' on each line item on the LINE ITEM SCREEN for that claim. The system will also enter, for the user, the paid amount for each line item in the amount identified for recoupment field on the LINE ITEM SCREEN.

NOTE: Users may remove 'Y' or 'N' flags on individual line items and change the amounts identified for recoupment for any line item on the LINE ITEM SCREEN regardless of whether the system populated the fields or the user.

5.1.2. For each 'Y' or 'N' entered on the CLAIM SET SCREEN, *the user* must select a valid reason code to explain why the claim is a duplicate or non-duplicate. Some reason codes also require a free-text explanation.

NOTE: Reason codes are only applied at the claim level on the CLAIM SET SCREEN. Reason codes are not required for each line item on the LINE ITEM SCREEN. In other words, only one reason code per claim is required.

5.1.3. For each 'Y' institutional claim identif*ied* as a duplicate payment *the user* must enter an identified amount for recoupment. For each 'Y' non-institutional claim line item identif*ied* as a duplicate payment, the system will enter the line item paid amount by default as the identified amount for recoupment.

NOTE: These amounts may be changed by the user if necessary.

5.1.4. For each 'Y' institutional or non-institutional claim identif*ied* as involving a duplicate payment, enter an amount actually recouped.

5.1.5. On the ADJUSTMENT SCREEN, *the user* may identify the TED adjustment transaction that corrects the duplicate condition in the TED database by entering a 'Y' in the **TED Adjust?** field of the adjustment displayed for the duplicate claim.

A duplicate claim set *can be resolved* in one of three ways:

- Indicate that no duplicate condition exits, enter a 'N' in the **Dupe?** field of all non-BASE claims, provide a non-duplicate reason code, and click the **RESOLVE THE SET** button to resolve the set and change the status to *Closed*.

- Indicate that one claim is a duplicate, enter a 'Y' in the **Dupe?** field, enter the amount identified for recoupment, enter the amount actually recouped, flag the appropriate TED adjustment that corrects the duplicate condition in the TED database, and click the **RESOLVE THE SET** button to resolve the set and change the status to *Closed*.

- Indicate that one claim is a duplicate, enter a 'Y' in the **Dupe?** field, enter the amount identified for recoupment, show that the amount actually recouped is less than the amount identified for recoupment, flag the TED adjustment (if any), click the **RESOLVE THE SET** button to resolve the set, enter an explanation for the lesser amount recouped, and allow the system to change the status to *Validate*.

The user can invoke the system's rules of resolution to resolve claim sets by clicking the **RESOLVE THE SET** button. When the **RESOLVE THE SET** button is clicked, the rules of resolution are invoked and the system determines if the set can be moved from *Open/Pending to Closed/Validate*. The end result of the status depends on the conditions in the set.

5.2. Rules Of Resolution

RULE 1: All claims in the set must have 'Y' or 'N' in the **Dupe?** field and a corresponding reason code.

RULE 2: There must be one claim that is labeled the BASE claim. This claim must have a 'N' in the **Dupe?** field.

RULE 3: All 'Y' claims must have an amount identified for recoupment greater than $0.00. When the first three rules are met, the status of the set changes to *Pending*.

RULE 4: If one or more actual duplicates are identified, but no amount can be recouped, the set can be resolved to a status of *Validate* if an explanation is provided.

RULE 5: If one or more actual duplicates are identified but the full amount identified for recoupment cannot be recouped, (i.e., the actual recoupment amount is less than the identified amount for recoupment), the set can be resolved to a status of *Validate* if the total TED adjustment amounts reflect the partial recoupment amount and an explanation for the reason the full amount could not be recouped is provided.

RULE 6: If one or more actual duplicates are identified but the amount actually recouped is $10.00 or less and the contractor does not intend to submit a TED adjustment for $10.00 or less for the refund/offset, the system will permit the set to be resolved to a *Validate* status provided that an explanation is entered.

RULE 7: If one or more actual duplicates are identified and the total amount identified for recoupment equals the total amount actually recouped and the total TED Adjust Amount is equal to the total actual recoupment amount, the set can be resolved. The *DCS* assumes that every duplicate non-institutional claim has corresponding TED adjustments for every

line item identified in the DCS as a potential duplicate. Resolution results depend on the following conditions:

5.2.1. If there is a corresponding TED adjustment for each institutional claim or each non- institutional line item identified as an actual duplicate, the set can be resolved to a *Closed* status without any explanation.

5.2.2. If there is not a corresponding TED adjustment for each institutional claim or non-institutional line item identified as an actual duplicate, the set can be resolved to a *Validate* status with an explanation for the reason corresponding adjustments were not submitted.

RULE 8: If all claims in the claim set have an 'N' in the **Dupe?** field, a valid 'N' reason code, $0.00 in the amount identified for recoupment and in the amount actually recouped for each claim, the set can be resolved to a *Closed* status. Some reason codes may require an explanation.

RULE 9: To resolve a claim set and change its status to *Closed* or *Validate*, the user must click the **RESOLVE THE SET** button. If the rules of resolution that apply to changing the status of a set from *Open/Pending* to *Closed/Validate* are met, the status of the set will be changed. If the rules of resolution are not met, the status of the set will not be changed.

RULE 10: The user can click the **UPDATE CHANGES** button to change the status of a claim set from *Open* to *Pending* or from *Pending* to *Open*. If the rules of resolution are not met, the status of the set will not be changed.

RULE 11: The user can leave a set and allow the system to automatically update the database and invoke the rules of resolution for changing the status from *Open* to *Pending* or from *Pending* to *Open*. If the rules of resolution are not met, the status of the set will not be changed.

The rules of resolution delineated above are overruled in *three* situations:

- In multi-contractor sets, the system ignores the claims in the set in which the **Owner FI** is not the **Responsible FI**, except for the BASE claim. It allows an **Owner FI** to move a set to a *Pending* status if there is one BASE claim and all the **Owner FI**'s claims meet the general conditions for *Pending*. That is: all **Owner FI** claims must have a **Dupe?** field entry and a reason code, there must be one 'Y' claim, and every 'Y' claim must have an identified recoupment amount greater than $0.00. See *Section 6, paragraph 2.0.*, for additional details.

- When a single contractor set is appended with a new claim, the status of the set becomes *Open*. When a multi-contractor set in *Open* status is appended with a new claim, the status of the set remains *Open*. When a multi-contractor set in *Pending* status is appended, the status of the set remains *Pending*. When a multi-contractor set in *Closed* status is appended, the status of the set is changed to *Open*. When a multi-contractor set in *Validate* status is appended, the status of the set is changed to *Pending*. See *Section 4, paragraph 5.0.*, for additional details.

- *Rule 8 does not apply to multi-contractor sets. In multi-contractor sets there must be at least one claim with a 'Y' in the* ***Dupe?*** *field.*

5.3. The RESOLVE THE SET, UPDATE CHANGES, And UNRESOLVE THE SET Buttons

The **RESOLVE THE SET** button and the **UPDATE CHANGES** button perform different resolution functions:

5.3.1. If *the user* wants to invoke the rules of resolution to see if the status of a set can be changed from *Open* to *Pending or Pending* to *Open*, *the user* must use the **UPDATE CHANGES** button.

5.3.2. If *the user* wants to invoke the rules of resolution to see if the status of a set can be resolved to a *Closed* or *Validate* status, *the user* must use the **RESOLVE THE SET** button.

5.3.3. *The user* cannot resolve a set to *Closed* or *Validate* status with the **UPDATE CHANGES** button.

5.3.4. If *the user* uses the **RESOLVE THE SET** button, the system will invoke the rules of resolution to determine if the status of the set can be changed to *Closed* or *Validate*. If neither of these conditions are met, the system will explain why the set cannot be resolved and will maintain the current status, i.e., *Open* or *Pending*.

If *the user* moves to another set after data on a set with an *Open* status *has been entered*, the system will automatically update the database with this new data and determine if the set meets the conditions for a *Pending* status. The change in status, if appropriate, will be made automatically, just as if the **UPDATE CHANGES** button *had been clicked*. Similarly, a *Pending* status will be changed to *Open* status if the rules dictate the set no longer meets the conditions for a *Pending* status. Note, however, that even if the set meets the conditions for a *Closed* or *Validate* status, this change will not be made automatically by the system. *The user* must use the **RESOLVE THE SET** button to change the status of a set to *Closed* or *Validate*.

The **UPDATE CHANGES** button appears on the screen whenever *the user* enters data. *The system* alerts *the user* to the fact that *new data has been* entered but this data has not been committed to the Duplicate Claims *d*atabase. When the **UPDATE CHANGES** button *has been clicked*, *the user* will be prompted to *select* one of the following:

- "Yes" to commit the changes to the database.
- "No" to rollback all the changes just made.
- "Cancel" to terminate the update function and return to the previous screen.

If *the user* chooses to commit the changes to the database, logic will be invoked to determine if the changes meet the rules of resolution for changing the status of the set from *Open* to *Pending* or from *Pending* to *Open*.

If *the user* chooses to rollback the changes just made, the screen will be reset to the way it was the last time the database was updated.

If *the user* chooses to cancel the operation, the update will not occur and *the user* will be back on the screen with the changes displayed but not committed to the database.

The **RESOLVE THE SET** button changes to an **UNRESOLVE THE SET** button when a claim set has been resolved and its status changed to *Closed* or *Validate*. New data cannot be entered into a set in *Closed* or *Validate* status. If *the user* wants to change data in a *Closed* or *Validate* set, *the user* must first unresolve the set by clicking the **UNRESOLVE THE SET** button, which automatically changes the status of the set to *Pending* or *Open*.

In the *DCS Open* and *Pending* are "working" statuses and *Closed* and *Validate* are "resolved" statuses. New data can be entered or changes to data can be made only to sets in a "working" status.

The **RESOLVE THE SET** and **UPDATE CHANGES** buttons described above allow *the user* to take definitive action to resolve and update a claim set. The system also has several default functions to manage these processes when *the user* enters new data and do not click the **UPDATE CHANGES** button. In other words, if *the user* leaves the claim set after entering data by one of the methods listed below, the system assumes *the user* forgot to click the **UPDATE CHANGES** button, and will do it. It also assumes *the user* wants to update the claim set with the data *that was* entered. In updating this data, the system invokes the rules of resolution to determine if the claim set meets the rules of resolution for changing the status of the set from *Open* to *Pending* or from *Pending* to *Open*. These actions will be triggered when *the user* leaves the claim set by one of the following methods:

- Click on one of the **VCR** movement buttons to move to the first, next, previous, or last claim set.
- Click on the **V**iew or **L**ocate menu bar function to move to a different claim set specified by the **V**iew or **L**ocate criteria.
- Click on the # **VCR** movement button to move to the claim set *the user* specifies.
- Exit from the *DCS*.

Be aware, however, that there is no default function for changing the claim set status to *Closed* or *Validate*. The only way a claim set can be fully resolved and the status changed to *Closed* or *Validate* is by clicking the **RESOLVE THE SET** button.

6.0. WORKING WITH MULTI-CONTRACTOR SETS

The important thing to remember when working with multi-contractor sets is that in every multi-contractor set, one or more jurisdictional errors were committed. One or more claims were paid by a contractor who did not have jurisdiction to do so. There must be at least one 'Y' claim in every multi-contractor set. If *the user is* the **Owner FI**, *the user* can view the set and enter data to try and resolve the set. If *the user is* not the **Owner FI** but paid one of the claims in the set, *the user* will not be able to view the set and, therefore, will not know that a jurisdictional error has been made until the **Owner FI** contacts *the user*.

The system designates the contractor who processed the latest claim as the **Owner FI**. If, after the two contractors discuss the jurisdictional facts, the other contractor (not the **Owner FI**) is the one responsible for the jurisdictional error, the current **Owner FI** should enter 'N' in the **Dupe?** field and a reason code, including BASE, if appropriate, for its claim, then change the **Owner FI** field to the other contractor by clicking the **M**odify function on the menu bar and selecting the **Owner FI** option. The contractor who processed the other claim in the set will be displayed so that *the user* can click on this contractor and change the **Owner FI** field to the other contractor. *The user* will be required to document that *the user* discussed this change in ownership with the other contractor and received approval to make the transfer. See *Section 6,* for additional details.

7.0. CREATING A REPORT

The user can click on the **R**eport function of the menu bar at any time to generate a report. *The user has* a choice of report formats and selection parameters from which to choose the layout and content of the report. For each report type, e.g., set reports, claim reports, summary/management reports, and graphs, *the user* will be prompted to select subsets within this report type (if applicable) and will be shown the REPORT PARAMETER SCREEN that looks similar to the **V**iew function screen. The REPORT PARAMETER SCREEN enables *the user* to select the claim types and set types that will be included in the report. See *Section 8,* for more details about using the **R**eport function.

8.0. CHANGING *A* PASSWORD

Passwords *can be changed* at any time*, j*ust click on the ***Profile*** *link on the PEPR Portal Toolbar (in the upper right side of the screen)* and follow the prompts. Passwords must have at least *nine but not more then twelve* characters and *use* at least *two of* each of the following*:* uppercase, lowercase, *n*umbers, and *s*pecial *c*haracters [**! @ # $ % ^ & * ( )** _]. Passwords *can* be changed *only once every 24 hours*.

9.0. *USING THE* HELP *SYSTEM*

If *the user* needs additional assistance beyond that provided by this chapter, *the user* can call the ***MHS*** **Help Desk** *in San Antonio* at **1-*800-600-9332****, then follow the prompts to DCS*.

DUPLICATE CLAIMS DATA

The Duplicate Claims System *(DCS)* performs several functions for the maintenance of the *DCS d*atabases. 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 *d*atabase. Subsequently, it identifies adjustment and cancellation transactions processed by the TED system associated with claims in the *DCS* Active and History *d*atabases 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 d*atabase.

1.5. DCS users work the sets in the DCS Active *d*atabase.

1.6. After specified conditions have been met and time periods have elapsed, DCS sets are moved to the DCS History *d*atabase.

1.7. After a specified period of time, the DCS sets are deleted from the DCS History *d*atabase.

The *DCS d*atabases 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 d*atabases 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 d*atabases.

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 d*atabases. *Prior to the National Provider Identifier (NPI) implementation, t*he *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. I*f 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.

Exact Match	All 12 fields match.
Near Match	*Five* fields match and the lesser Billed Amount is within 10% of the larger Billed Amount.
Date Overlap	*Three* fields match and the beginning date of care of one claim falls between the beginning and ending dates of another.
Other	*Four* fields match.
Other Inst	*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).*

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
CLAIM LEVEL				
PATIENT ID	✔	✔	✔	✔
PATIENT DOB				✔
PRIN DIAGNOSIS				✔
LINE ITEM LEVEL				
PROVIDER TAX NBR	✔	✔	✔	✔
PROVIDER SUB ID	✔	✔	✔	✔
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.*

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
CLAIM LEVEL							
PATIENT ID	✔	✔	✔	✔	✔	✔	✔
PATIENT DOB							✔
PROVIDER ID							✔
PROVIDER SUB ID							✔
NPI - TYPE II	✔		✔		✔		✔
NPI - TYPE I		✔		✔		✔	✔
PRIN DIAGNOSIS							✔
LINE ITEM LEVEL							
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).

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. Prior to the 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[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

[1] **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.*

CLAIM SETS AND THE CLAIM SET LIFE CYCLE

An understanding of claim sets and the claim set life cycle is a prerequisite for using the Duplicate Claims System *(DCS)*. All potential duplicate claims are grouped into sets. Each claim set is unique. Each claim set is assigned a unique and sequential claim set number for reference and control purposes.

1.0. DEFINITION OF A CLAIM SET

A claim set is composed of two or more TRICARE Encounter Data (TED) records meeting either one of four institutional match criteria, or one of four non-institutional match criteria described in *Section 3, paragraph 2.0.* These match criteria are used by the system to identify and select claims that are potential duplicates.

Each claim set contains one and only one claim record that is initially assigned by the system to be the BASE claim, signifying the claim with the earliest processed to completion *(PTC)* date. By default, the system assumes that the BASE claim is the one least likely (with exceptions) to be a duplicate of another claim in the set because it was processed and paid before the other claim(s) in the set. The non-BASE claim(s) are considered to be potential duplicates.

The assignment of the BASE claim also applies to sets containing claims that were processed by two different contractors. These sets are referred to as multi-contractor sets. In multi-contractor sets, the duplicate payment is assumed to be a result of a jurisdictional processing error. In such cases, the claim with the earliest *PTC* date could be the actual duplicate. In both single contractor claim sets and multi-contractor claim sets, the contractor is able to change the BASE claim assignment and assign a different claim in the set as the BASE claim.

1.1. Institutional Claim Sets

The *DCS* applies *the* institutional match criteria to institutional claims at the claim level to identify potential duplicates. In general, an institutional claim will appear in only one set. If, however, a contractor submits a TED adjustment and changes a claim's date of service, the claim may subsequently appear in another set. When a claim appears in more than one set, the *Internal Control Number (*ICN*)* of the claim will be displayed in the CLAIM SET SCREEN in white letters and numbers. Additional claims may be added to a set at any time, providing they meet the match criteria.

EXAMPLE: If institutional claim A and institutional claim B are identified as potential duplicates, they will appear in Claim Set 1. If another claim, institutional claim C, is identified as a potential duplicate of either claim A or claim B, the system will add claim C to Claim Set 1. If an adjustment to claim B changes the dates of

service for the claim, claim B should be labeled as a non-duplicate claim in Claim Set 1. If claim B, as it appears with the revised dates of service, is identified as a potential duplicate of another institutional claim D, claims B and D will be grouped into a new Claim Set 2.

1.2. Non-Institutional Claim Sets

The *DCS* takes a different approach to identifying and linking potential non-institutional duplicate claims. Non-institutional potential duplicates are identified by comparing line item data of one claim with line item data of another claim.

NOTE: The *DCS* does not look for duplicates within a single claim; only among two or more claims.

When a line item of one non- institutional claim is identified as a potential duplicate of a line item of another non-institutional claim, the system groups the claims with the matching line items into a set.

For example, if line item number 5 of claim D is identified as a potential duplicate of line item 7 of claim E, the system will group the two potential duplicate line items into Claim Set 2. Any additional line items on claims D and E identified as potential duplicates of each other will also be included in Claim Set 2 if the beginning date of service is the same as the other potential duplicate line items in the set. All of the line items contained in Claim Set 2 must have the same beginning date of service.

1.2.1. Display Of Line Items In Non-Institutional Claim Sets

Non-institutional sets contain only those line items that have been identified as potential duplicates. Any line item not identified as a potential duplicate will not be included in the claim set. For example, if claim D contains five line items and claim E contains five line items, but only line items 1, 3, and 5 on claim D are identified as potential duplicates of line items 1, 2, and 4 on claim E, the claim set will include only those matched line items. Line items 2 and 4 from claim D and line items 3 and 5 from claim E will not appear in the claim set.

If, after a set has been established, the system detects potential duplicate line items from additional (e.g., a third and fourth) non-institutional claims that match the line items previously identified and have the same beginning dates of service, the system will add the new claims to the existing claim set. If, however, the identified line items from the third and fourth claims have different beginning dates of service, the system will create a new claim set composed of the matching line items from the third and fourth claims as long as they have identical beginning dates of service. If a contractor submits a TED adjustment that changes a line item's date of service, the line item may subsequently appear in another set.

For non-institutional potential duplicate claims to appear in the same claim set, the claims must have matching Patient IDs; provider tax ID and sub-ID numbers; and beginning dates of service.

1.2.2. Examples Of Non-Institutional Claim Sets

1.2.2.1. If Claim Set 4 contains two claims, F and G, with line item 2 on both claims showing services rendered to Sally Jones for an office visit with Dr. Smith on May 1, 2005, these line items would be matched up in one set. Later, however, if claims H and I come in for Sally Jones, both containing a line item for an office visit on October 1, 2005 with Dr. Smith, the system will group the line items with the October 1, 2005 date of service from claims H and I into a new claim set (Claim Set 5). The system will not include them in the claim set containing the line items for the May 1, 2005 office visit (Claim Set 4)--even though the line items are for the same procedure code, for the same beneficiary, and rendered by the same provider---because the beginning dates of care are different. The system will prevent contractors from having to research claims containing line items that are related to different episodes of care within the same claim set.

1.2.2.2. Claim Set 6 contains two claims, J and H, both containing one line item for services rendered to Sally Jones. The line items are for office visits with Dr. Smith on May 1, 2005. Later, claims L and M are received for Sally Jones containing two line items each. Line item 1 on claims L and M is for a minor outpatient surgical procedure for Sally Jones (removal of an ingrown toe nail) by Dr. Smith on May 1, 2005. Line item 2 on both claims are for office visits for Sally Jones on June 1, 2005 with Dr. Smith.

The system will match the May 1, 2005, line items from claims L and M with the line items from claims J and K. Claim Set 6 will now contain four line items from four different claims. However, because line item 2 on claims L and M have a different beginning date of service, (June 1, 2005), the system will create a new claim set (Claim Set 7) for line item 2 of claims L and M. These line items will not be added to Claim Set 6.

As a result, claims L and M will appear in both Claim Set 6 and Claim Set 7, with each claim set containing different line items. When the user is researching claims J, K, L, and M in Claim Set 6, the system will alert the user that claims L and M also appear in another claim set by changing the color of the ICN of claims L and M from black to white. The system will permit the user to move directly to the "next" or "previous" claim set where L and M appear when the user double clicks on the ICNs shown in white.

1.3. Adjustments And Cancellations Associated With Claims In A Set

Following every TED processing cycle, generally on a daily basis, the DCS identifies all accepted adjustment and cancellation TEDs which are associated with any of the TEDs previously extracted as potential duplicates and residing in the DCS Active database. These adjustments and cancellations are extracted from the TED database and added to the applicable claim sets in the DCS Active database.

Adjustments to an institutional potential duplicate claim residing in the DCS are extracted and linked to the appropriate institutional claim set. Adjustments to a line item of a non-institutional potential duplicate claim residing in the DCS are extracted and linked to the appropriate non-institutional claim set.

1.4. ICNs Versus Claims

ICNs in the *DCS* do not necessarily equate to a claim. A "claim" is identified by an ICN and a time stamp. The *DCS* considers different time stamps to the same ICN to be unique claims.

2.0. THE PURPOSE OF CLAIM SETS IN THE *DCS*

The primary purpose of creating claim sets is to establish a method by which potential duplicate claims are linked together. Claim sets are the distinguishing unit of categorization in the *DCS*. They identify a unique grouping of claims and line items that meet one or more match criteria and therefore are potential duplicates. Each claim set contains at least two claims. Each claim set is identified by:

- A Set Number
- A Status Code
- A Match Type
- An **Owner FI**
- An **Owner Region**

Each set also maintains totals of recoupment activities completed to date. Specifically, the set contains totals of the amounts identified for recoupment, totals of the amounts actually recouped, and totals of the paid amounts of adjustment and cancellation TEDs.

A claim set provides descriptive data about the claims in the set and the status of the set as it moves through the claim set life cycle to final resolution. TED data such as the ICN, *PTC* date, *Patient ID,* and other patient, provider and service data are displayed for each claim. Claim sets also contain fields that require contractor entry of data to resolve the set.

3.0. THE CLAIM SET LIFE CYCLE

The DCS is comprised of three databases. The first is the *DCS* Load *d*atabase where the TED extracts are processed for "loading" into the DCS Active *d*atabase. The second is the *DCS* Active *d*atabase and the third is the *DCS* History *d*atabase. Sets are worked in the Active *d*atabase. Sets that have met certain criteria and that have resided in the Active *d*atabase for specified periods of time are archived to the History *d*atabase. See *Section 3, paragraph 1.0.* and paragraphs 4.3., 4.4., and 7.0. for details regarding the *DCS* History *d*atabase. See *Section 3, paragraph 1.0.* for information regarding the DCS Load *d*atabase.

The claim set life cycle is the foundation of the *DCS*. Claim sets in the *DCS* are given a claim set life cycle stage, i.e., a set status, to manage the resolution process. The claim set life cycle tracks each claim set as it moves through the resolution process.

In order to resolve a claim set, the contractor must identify actual duplicate claims payments, recoup the overpayments and remove duplicate conditions from the TED database. Or, the contractor must explain why the claims identified as potential duplicates are not actual duplicates (e.g., twins who have received identical services). Additionally, a claim set may contain claims that are in fact actual duplicates yet none or only a portion of

the monies identified for recoupment can be collected. In cases such as these, the system allows the contractor to resolve the claim set provided that an explanation for the absent or reduced recoupment is provided. The system has internal controls to ensure that the resolution process includes appropriate contractor action to fully or partially correct the duplicate condition in the TED database.

The claim set life cycle is composed of four stages. Each stage signifies a set status. The *Open* and *Pending* stages are considered "working" stages. Claim sets with an *Open* or *Pending* status have not been resolved. The *Closed* and *Validate* stages are considered "resolved" stages. Claim sets in the *Closed* or *Validate* status have been resolved and the appropriate rules of resolution satisfied. The four claim set life cycle stages are described below:

3.1. The Open Stage Of The Claim Set Life Cycle

This stage is the first stage in the claim set life cycle. The *Open* status is given to all claim sets when they are initially loaded into the *DCS* Active *d*atabase. In this stage, claim sets are shown with a status of *Open*, meaning that the claim set has not been researched by the contractor to determine:

- If actual duplicate payments were made on any of the claims in the set;
- The reason why a duplicate payment was made or why the apparent duplicate is not a duplicate; and
- The amount identified for recoupment, where applicable.

3.2. The Pending Stage Of The Claim Set Life Cycle

Normally, this is the second stage in the claim set life cycle. A set in *Pending* status means that the set is "Pending Recoupment". This status indicates that the contractor has completed the necessary research to determine which claims are actual duplicates and which claims are non-duplicates. At least one claim in the set must be an actual duplicate in order for the set to be in the *Pending* status. Additionally, all actual duplicates must have an amount identified for recoupment.

3.3. The Closed Stage Of The Claim Set Life Cycle

This stage is considered the final stage in the claim set life cycle. It indicates that the claim set has met all of the criteria for the set to be fully resolved. The *Closed* status means that:

- All actual duplicate claims in the set have been identified with an amount identified for recoupment;
- All claims in the set have reason codes assigned;
- The full amount entered in the amount identified for recoupment was received in offsets or refunds; and
- Adjustments were submitted that reflect the recoupments and correct the duplicate conditions on the TED database.

A set also can be *Closed* when all claims in the set are identified as non-duplicates.

3.4. The Validate Stage Of The Claim Set Life Cycle

This stage in the claim set life cycle is a final, but conditional, stage. It indicates that the set did not meet the rules of resolution for fully resolving the set. For example, if only 80% of the amount identified for recoupment was collected, the system will not allow the set to be *Closed*. *Validate* status means that the full amount identified for recoupment could not be recovered and the reasons and circumstances for the reduced recoupment amount have been explained and that the contractor has "validated" that required recoupment procedures for uncollected debts have been followed. By having a separate status for sets involving incomplete recovery of identified recoupments, contractors and the TMA can readily identify the involved sets and claims within the *DCS*. *Validate* status means that:

- All actual duplicate claims in the set have an amount identified for recoupment;
- All claims in the set have reason codes assigned;
- The actual amounts recouped by refund or offset have been entered and that less than 100% of the amount identified for recoupment has been collected;
- An explanation for the lower recoupment amount has been entered;
- The TED database has been updated to reflect any refunds received or offsets taken; and
- Required recoupment procedures have been followed as they relate to uncollected debts. The explanation entered into the system must include the user's name, the date, and the reason for the lower recoupment amount.

The *Validate* status is also used in one other circumstance. When the amount actually recouped is $10.00 or less and the contractor chooses not to submit a TED adjustment, an explanation must be entered to that effect, and then the set can be resolved to a *Validate* status.

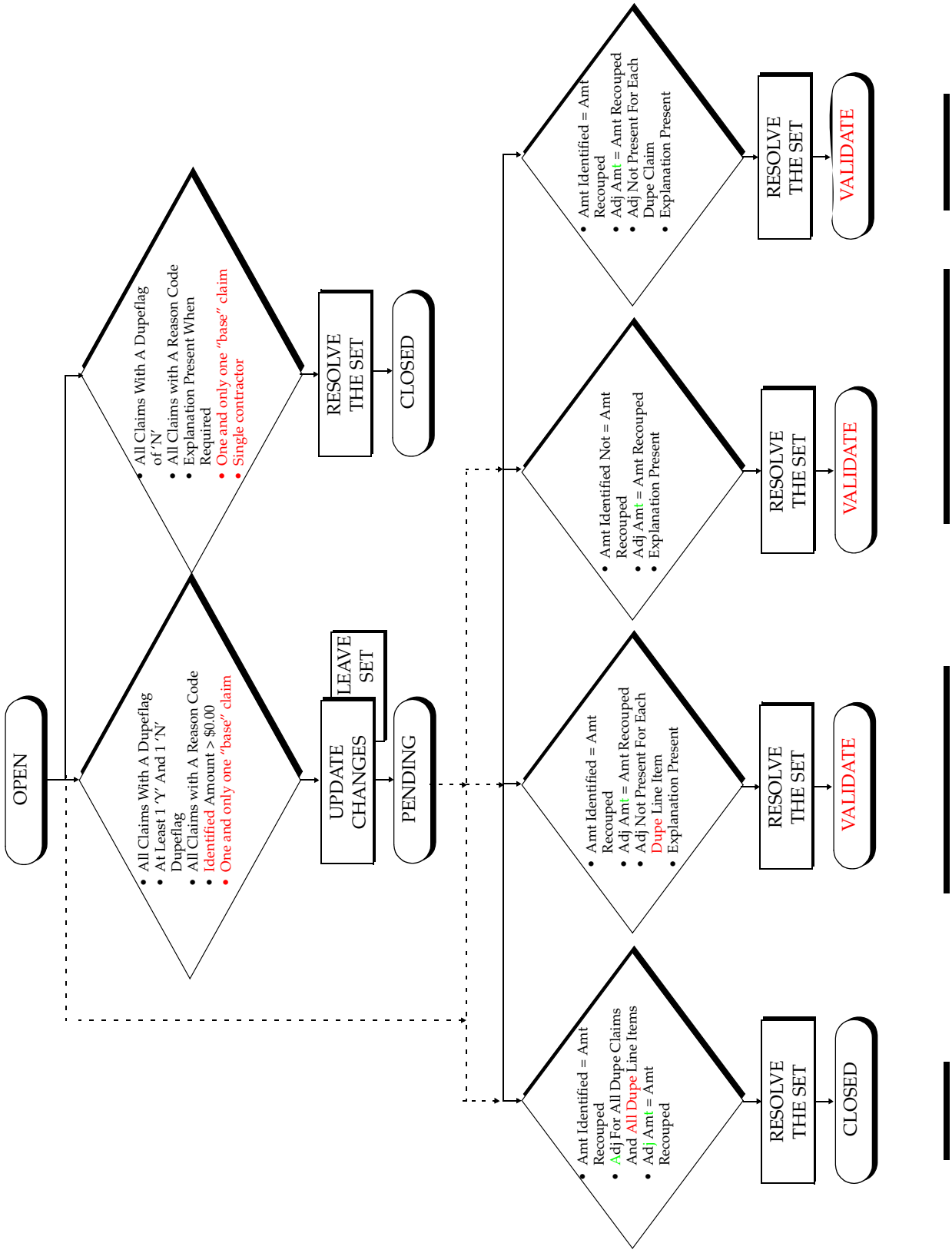
4.0. EXAMPLES OF SETS AT EACH STAGE OF THE CLAIM SET LIFE CYCLE

Each claim set has a status (e.g., *Open*) that corresponds to a stage of the claim set life cycle. The rules of resolution determine which status is given to each set. Figure 10-4-1, is a flow diagram of the rules of resolution. It shows how the rules of resolution dictate changes to claim set status.

The status of a set changes as the user enters data in five fields:

- The **Dupe?** field(s)
- The **Reason Code** field
- The **Identified Recoup** field(s)
- The **Actual Recoup** field
- The **TED Adjust?** field

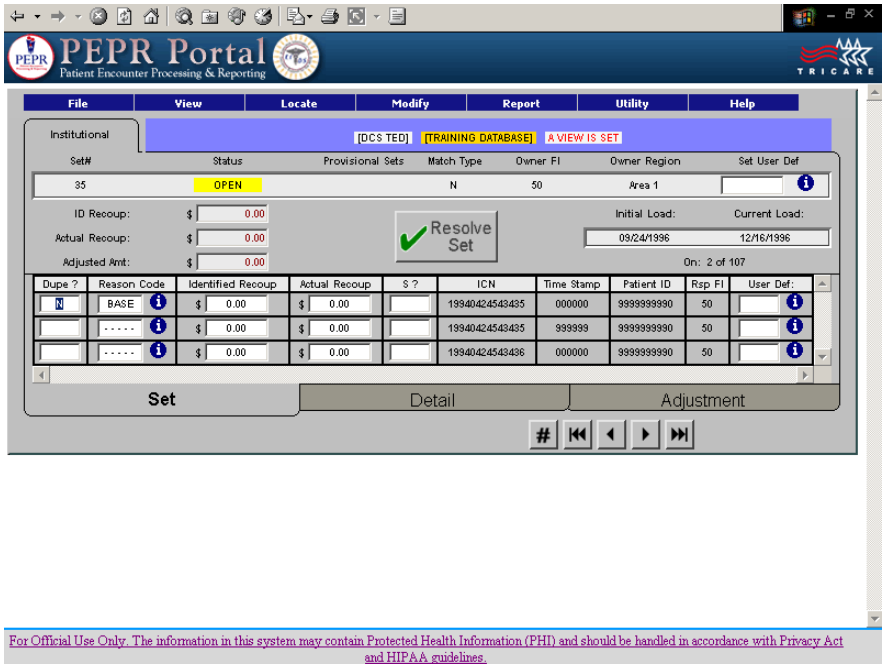
FIGURE 10-4-1 RULES OF RESOLUTION



4.1. Open Claim Sets

This status indicates that the claim has not met the conditions defined in the rules of resolution for any other stage in the claim set life cycle. Essentially, *Open* claim sets are awaiting research by the contractor and subsequent action in the *DCS*.

FIGURE 10-4-2 SAMPLE OPEN SET



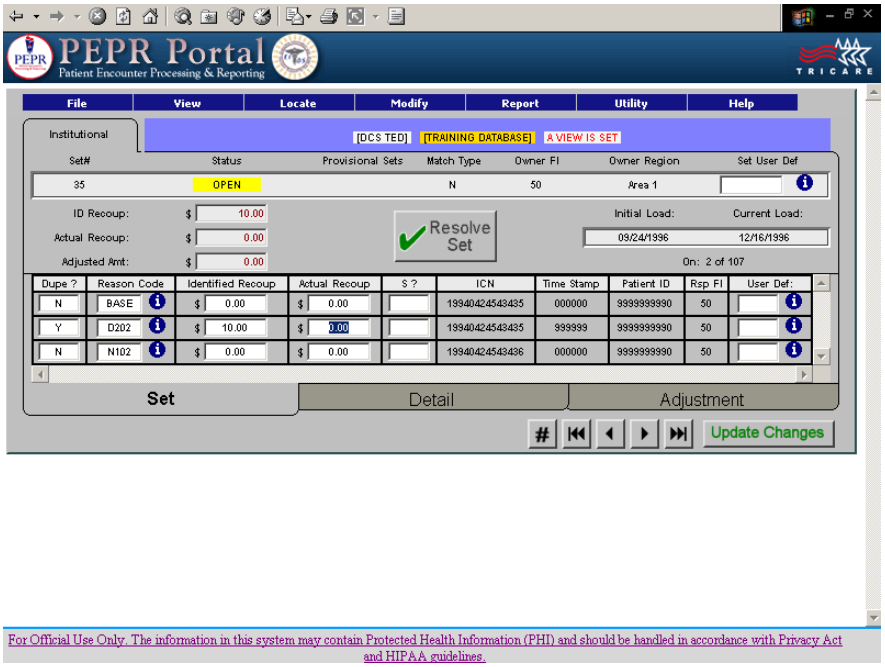
An example of a claim set with an *Open* status is shown in Figure 10-4-2. As shown in this figure, the contractor has not entered any data in the user-controlled fields of this set (e.g., **Dupe?**, **Reason Code**, **Identified Recoup**).

To move a set out of *Open* status, the user must enter data and invoke the rules of resolution. The user can invoke the rules of resolution by clicking the **UPDATE CHANGES** button to see if the status can be changed to *Pending*. The user also can invoke the rules of resolution by clicking the **RESOLVE THE SET** button to see if the status can be changed to *Closed* or *Validate*.

4.2. Pending Claim Sets

The status of a claim set can be changed from *Open* to *Pending* when a contractor completes the research and determines that the set contains one or more duplicates. After entering a 'Y' in the **Dupe?** field for each duplicate *(Figure 10-4-3)*, identifying the reason for each duplicate, and identifying the amount that should be recouped for each duplicate, the contractor can invoke the rules of resolution to determine if the status of the set can be changed to *Pending*.

FIGURE 10-4-3 OPEN TO PENDING CLAIM SET



In order for the status of a claim set to be changed from *Open* to *Pending*, the contractor must either click the **UPDATE CHANGES** button or leave the claim set and allow the system to make the change. In either case, the system checks for the following conditions:

- All **Dupe?** fields have a 'Y' or 'N'.
- There is at least one 'Y' and one 'N'.
- There is one BASE claim.
- All claims have a reason code.
- All 'Y' claims have an amount identified for recoupment greater than $0.00. *(If multi-FI set, see Section 6, paragraph 2.4.)*

To save changes, click the UPDATE CHANGES button. For an example of the UPDATE CHANGES SCREEN, see Figure 10-4-4. The following options are available:

- *"Yes" to save all changes.*
- *"No" to rollback all changes.*
- *"Cancel" to quit.*

FIGURE 10-4-4 ***UPDATE CHANGES SCREEN***

An example of a *Pending* claim set is shown in *Figure 10-4-5*. Contractors should not initiate recoupment action on an actual duplicate claim until the set has been moved to *Pending* status.

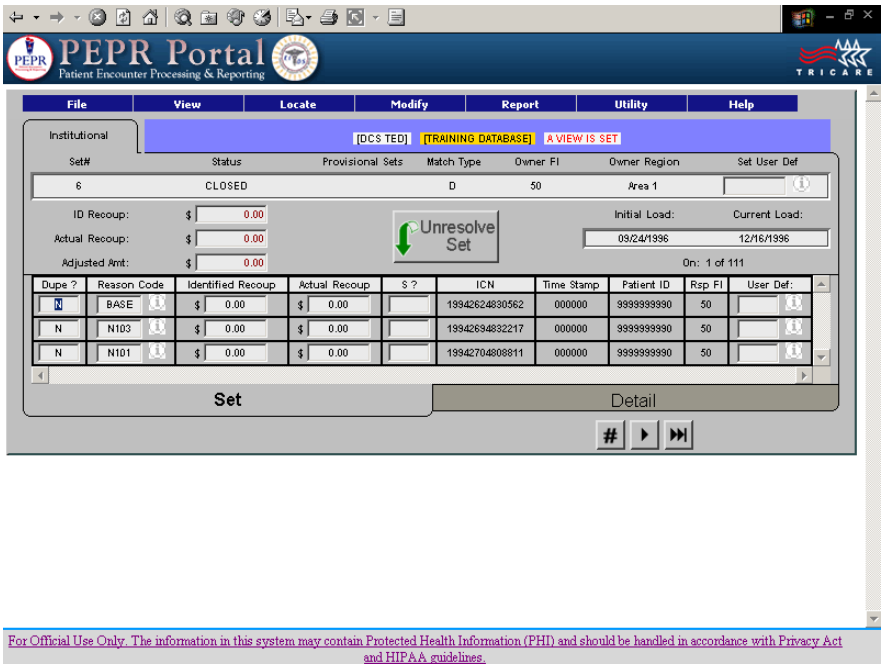
FIGURE 10-4-5 **SAMPLE PENDING SET**

Because the **UPDATE CHANGES** button activates code that determines if a claim set meets the conditions for a *Pending* status, it also can be clicked to change the status from *Pending* back to *Open* when the *Pending* conditions are no longer met.

4.3. Closed Claim Sets

This status indicates that the claim set has met the conditions defined in the rules of resolution for full resolution. These conditions require full recoupment of all actual duplicate payments identified in the claim set. Also, TED adjustments corresponding to the amounts actually recouped must be flagged. If the *single-contractor* set does not contain any actual duplicates, it can be resolved to a *Closed* status provided that each claim has a 'N' in the **Dupe?** field, a valid reason code and, if required, an explanation. *If it is a multi-contractor set, it must contain at least one claim with a 'Y' in the* ***Dupe?*** *field.*

FIGURE 10-4-6 SAMPLE CLOSED SET



An example of a claim set in *Closed* status is shown in *Figure 10-4-6*. As described in *Section 2, paragraph 5.3.*, the **RESOLVE THE SET** button must be clicked to change the status of a claim set to *Closed*. Before this action, the status of the set may be *Open* or *Pending*. To meet the conditions for changing the status to *Closed* when one or more actual duplicates have been identified, the following conditions must be met:

- All **Dupe?** fields must have a 'Y' or 'N'.
- There must be at least one 'Y' and one 'N' in the set.
- All claims must have a valid reason code (some reason codes require a free-text explanation).
- The total amount identified for recoupment must be greater than $0.00.
- The total amount identified for recoupment must equal the total amount actually recouped.

- The total TED adjustment paid amounts flagged must be equal to the total amount actually recouped.
- Every duplicate claim and every duplicate line item must have a corresponding HCSR adjustment.

If no actual duplicates have been identified in a set, the following conditions must be met to change the status to *Closed*:

- All claims in the set must have a 'N' in the **Dupe?** field.
- All claims in the set must have a valid 'N' reason code.
- All **Identified Recoup** and **Actual Recoup** fields must equal $0.00.

Closed claim sets remain on the DCS Active *d*atabase for two years, at which time they are moved to the DCS History *d*atabase where they are kept for an additional seven years. The system does not allow users to modify any of the fields in a *Closed* set unless the set is "unresolved" (i.e., moved back to the *Open* or *Pending* status by clicking the **UNRESOLVE THE SET** button). *Closed* sets in the DCS History *d*atabase are deleted after seven years.

4.4. Validate Claim Sets

This status indicates that the claim set has been resolved but the resolution did not meet the *Closed* status conditions, i.e., the full amount was not refunded or offset. The set may meet one of the four conditions for changing the status to *Validate*, as shown in *Figure 10-4-7*.

FIGURE 10-4-7 CONDITIONS FOR CHANGING CLAIM SET STATUS TO VALIDATE

CONDITION 1	CONDITION 2	CONDITION 3	CONDITION 4
The total amount identified for recoupment is not equal to the total amount actually recouped.	The total amount identified for recoupment is equal to the total amount actually recouped.	The total amount identified for recoupment is equal to the total amount actually recouped.	The total amount recouped is less than or equal to $10.00.
and	**and**	**and**	**and**
The sum of the paid amount(s) for all selected adjustments is equal to the total amount actually recouped.	The sum of the paid amount(s) for all selected adjustments is equal to the total amount actually recouped.	The sum of the paid amount(s) for all selected adjustments is equal to the total amount actually recouped.	No adjustment was submitted by the contractor for the $10.00 or less recoupment.

FIGURE 10-4-7 CONDITIONS FOR CHANGING CLAIM SET STATUS TO VALIDATE

CONDITION 1	CONDITION 2	CONDITION 3	CONDITION 4
and	**and**	**and**	**and**
The user enters an explanation for the discrepancy in the total amount identified for recoupment and the total amount actually recouped.	There is not a selected adjustment for every claim with a **Dupe?** of 'Y'.	There is at least one selected adjustment for every claim with a **Dupe?** of 'Y'.	The user enters an explanation that no TED adjustment will be submitted for a refund of $10.00 or less.
	and	**and**	
	The user enters an explanation for the discrepancy in the number of adjustments flagged and the number of claims with a **Dupe?** of 'Y'.	There is not a selected adjustment for every non-institutional line item with a **Dupe?** of 'Y'.	
		and	
		The user enters an explanation for the discrepancy in the adjustment line items flagged and the line items with a **Dupe?** of 'Y'.	

An example of a claim set with a *Validate* status is shown in *Figure 10-4-8*. As shown in this figure, the sum of the amount identified for recoupment, the sum of the amount actually recouped, and the sum of the associated TED adjustment paid amounts satisfy condition 1 for changing the status to *Validate*.

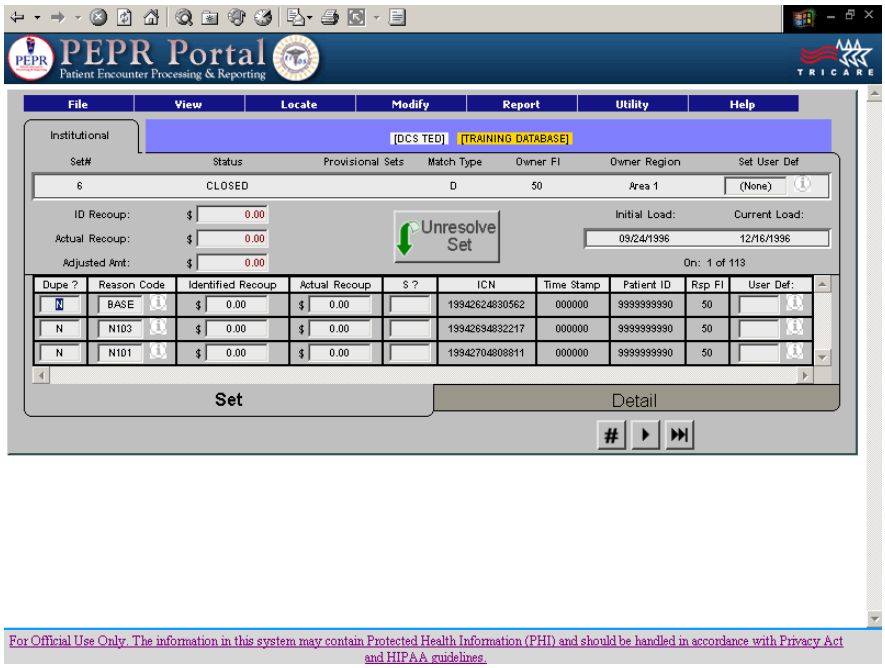
When a user clicks the **RESOLVE** button to resolve a set that does not meet the full recoupment conditions required to change the status to *Closed*, the system will present the user with the condition(s) under which full recoupment requirements were not met. The system will then prompt the user to continue with resolution. If the user elects to continue and the set meets one of the *Validate* conditions, the system will display a pop-up screen requesting an explanation for the *Validate* status. The user is required to type in their name, the date, and explanation for the *Validate* situation.

Validate claim sets remain on the DCS Active database for five years, at which time they are moved to the DCS History database where they are kept for an additional seven years. The system does not allow users to modify any of the fields in a *Validate* set unless the set is "unresolved" (i.e., moved to an *Open* or *Pending* status by clicking the **UNRESOLVE SET** button). *Validate* sets in the DCS History database are deleted after seven years.

FIGURE 10-4-8 SAMPLE VALIDATE SET

It should be noted that any *Closed* or *Validate* set may be moved from *Closed* or *Validate* status back to a *Pending* or *Open* status in the DCS Active *d*atabase by clicking the **UNRESOLVE SET** button *(Figure 10-4-9)*. It should also be noted that if a new potential duplicate claim is identified which belongs in a *Closed* or *Validate* set residing in the DCS Active *d*atabase, the system will add the new potential duplicate to the *Closed* or *Validate* set and change the status of the set to *Open* or *Pending*.

FIGURE 10-4-9 *UNRESOLVE SET*



5.0. APPENDING NEW CLAIMS TO EXISTING SETS DURING THE MONTHLY EXTRACT CYCLE

During each monthly extract cycle, new claim sets are added to the *DCS* Active *d*atabase. At the same time, if a new claim is identified as a potential duplicate of a claim in an existing set, it is added to the existing set. These sets are called appended sets. As the system appends these new claims to their appropriate sets, the system determines if the current **Owner FI** should be changed. It also determines if the status of the set should be changed.

5.1. Determining The Owner FI Of Appended Sets

The system applies the general rule of assigning the **Owner FI** to the **Responsible FI** of the claim with the latest PTC date if the status of the set is *Open* or *Closed*. If the status of the set is *Pending* or *Validate*, the system ignores this rule and leaves the current assignment of the **Owner FI**.

5.2. Determining The Status Of Appended Sets

All single contractor appended sets become *Open* sets. All multi-contractor appended sets are moved out of a resolved status (i.e., *Closed* or *Validate*) to a working status (i.e., *Open* or *Pending*). For multi-contractor appended sets, the following changes are applied:

- Appended sets in a *Closed* status are changed to *Open* status.
- Appended sets in a *Validate* status are changed to *Pending* status.
- Appended sets in a *Pending* status remain *Pending* sets.
- Appended sets in an *Open* status remain *Open* sets.

6.0. LOAD DATES

The *DCS* assigns two Load Dates (**Initial Load Date** and **Current Load Date**) to each set when loaded to the DCS. When a set is first loaded, both the **Initial Load Date** and the **Current Load Date** are the same. The **Initial Load Date** remains unchanged throughout the life cycle of the set. The **Current Load Date**, which is used in calculating compliance with the performance standards for the DCS (see *Section 9, paragraph 8.0.*), may change. There are two circumstances under which the **Current Load Date** could change. These circumstances are:

- When the **Owner FI** changes.
- When a set is appended with a new claim.

7.0. HISTORY DATABASE

The *DCS* History *d*atabase contains sets that had been in the DCS Active *d*atabase in *Closed* or *Validate* status for either two or five years respectively. The data in the History *d*atabase is read only. While users cannot change any data in the History *d*atabase, they can run reports. Certain TMA and contractor users have permission to "Unarchive" a set in the History *d*atabase (i.e., move the set back to the DCS Active *d*atabase where changes may be made. (See *Section 2, paragraph 1.0.*, for instructions for accessing the History *d*atabase.)

USER'S GUIDE

This section is a detailed user's guide to essential system functions. It provides examples to illustrate system capabilities and describes how users can access the system appropriately. Although it contains information that appears in other sections of this document, this section particularly focuses on user screens and functions designed to resolve duplicate claim sets.

1.0. AUTHORIZED USERS

The Duplicate Claims System *(DCS)* distinguishes among *four* groups of users:

- Contractors are the primary users. They have read/write access to the data. They use the system to resolve claim sets by viewing potential duplicate claims, identifying actual duplicates, and monitoring recoupment activities.
- *Select contractor personnel may have read/write/admin access to the database. These users have permissions to create activate and deactivate user-defined codes or unarchive sets from the history database or both.*
- TMA/Government personnel access the system to monitor duplicate claims resolution activities, generate management reports, and evaluate contractor performance. These users have read-only access to the system.
- The*re is also a* group of users *comprised of* a very limited number of TMA staff who *are "Super Users" and can exercise all functions within the DCS to include changing set status*.

1.1. Contractor Users

Contractor users have read/write access to the data. Certain contractor users have additional permissions to perform functions within the DCS that are not available to all contractor users *and have read/write/admin permissions* (*Section 3, paragraph 2.5.*). Such functions include establishing claim and set level user defined codes and returning archived sets to the production database. Contractors are required to use the system. Each contractor has limited access to the claim sets in the database. In general, this means that contractors have access only to their own claim sets, i.e., sets containing claims they processed or inherited from a previous contractor during a transition. The system uses the **Owner FI** field to maintain this

control of sets. The system uses two other fields to refer to a specific contractor. These fields are discussed below:

1.1.1. Processing FI

This field refers to the contractor who processed the claim and submitted the associated TED. This field never changes.

1.1.2. Responsible FI

This field refers to the contractor who currently is responsible for a specific claim in a claim set. In most instances, the **Responsible FI** will be the contractor who processed the claim. However, if the Processing FI is no longer responsible for this claim (e.g., due to a contractor transition), the **Responsible FI** will be a different contractor. A contractor cannot change the **Responsible FI** (**Rsp FI**) field.

(See Section 7, for an explanation of how the system uses the mass change function to reassign the **Responsible FI** for existing claims in the system following a change in contractors.)

1.1.3. Owner FI

The **Owner FI** identifies the contractor responsible for (i.e., "owns") a set. Initially, the **Owner FI** is assigned by the system during the loading of the claim set. The system looks at all of the claims in the set and selects the contractor who submitted the claim with the most recent processed to completion *(PTC)* date. In most instances, a single contractor will have submitted all the claims in the claim set so the **Owner FI** will be the same as the **Responsible FI** on the claims. However, if more than one contractor processed and submitted the claims in a set, the system determines which contractor submitted the claim with the latest *PTC* date. This contractor is designated as the **Owner FI** and becomes responsible for the resolution or transfer of the claim set. Under certain circumstances during a contractor transition or during the resolution of a multi-contractor claim set, the **Owner FI** may change. See *Sections 6* and *7*, for additional details.

1.2. TMA/Government Users

The TMA is responsible for a number of contract administration and evaluation activities, including the monitoring of contractor duplicate claim resolution activities. TMA personnel use the *DCS* to generate management reports and monitor contractor performance. The TMA will audit claim sets in the various stages of the claim set life cycle. For example, *Validate* claim sets may be periodically audited to verify that complete refunds of identified recoupment amounts could not be collected and that required recoupment procedures had been followed. *Closed* claim sets containing non-duplicates may be audited to verify that all of the claims in the set were not duplicates. *Pending* claim sets may be audited to verify compliance with recoupment requirements and timeliness standards.

The *DCS* provides the TMA with the capability to audit contractors for compliance with system requirements governing "ownership" transfers of multi-contractor sets, the selection of accurate and appropriate reason codes, and the adequacy of the explanations

entered into the system for any of the above. In short, any and all aspects of using the *DCS*, its data, and its output are subject to audit by TMA or other Government auditing personnel. The TMA is also responsible for initiating data administration and system maintenance activities associated with extracting and loading TEDs to the *DCS* and for performing mass change functions for contractor transitions.

1.3. Selected TMA Personnel

A limited number of TMA personnel have read/write access to the system *and are considered "Super Users"*. These personnel use their read/write access for system and data integrity management purposes. *Government "Super Users" will not change data without the knowledge of the* ***Owner FI****.*

2.0. REQUIREMENTS FOR ACCESSING THE SYSTEM

User access to the system is controlled by security procedures that require an individual to have access to the Government's servers and the *DCS*. Security procedures require a valid user ID and password.

2.1. User ID And Password

A critical component of system security is the assignment of unique user identification numbers (IDs) and passwords for each individual authorized to access the system.

Individual users at contractor and TMA sites have the capability to define their own passwords for accessing the *DCS*. Users can change these passwords at *the* time *of log on to the Patient Encounter Processing and Reporting (PEPR) Portal*.

As previously stated, the system allows access to those functions authorized and associated with particular user IDs. For example, contractors are permitted access only to those potential duplicate claim sets for which they are the **Owner FI**. Also, they are permitted to generate reports based only upon their own data. The same restriction to accessing data applies to the downloading function. TMA users are authorized to access claim sets for any and all contractors. Additionally, they have access to a number of administrative functions, such as generating management reports containing the aging of claims data in the aggregate, by region, or by specific contractor.

2.2. Signing On To The System

After a user has *passed* the *PRIVACY ACT* SCREEN, user log-on is directed by a screen that queries the user for an ID and password. The User ID determines what level of access is permitted and what data (claim sets) can be viewed. Once a valid User ID and password are entered, *the user is* connected to the *DCS*.

The claim set life cycle and the resolution of duplicate claim sets begin when contractors sign on to the *DCS* to view and examine potential duplicate claims (see *Section 3, paragraph 2.0.*, for a description of the claims selection criteria). Through menus, contractors

can define parameters to create a filter for the types of claim sets they want to view (see paragraph 4.1.2., for details regarding the View function.)

2.3. Accessing Claims Data

The *DCS* uses the **Owner FI** field to identify and limit access to claims data. The **Owner FI** is responsible for resolving the claim set. The system allows only the **Owner FI** to view the claim set and enter data to resolve the set. The **Owner FI** is solely responsible for researching and resolving the claim set. No other contractor can view or access a claim set owned by another contractor.

3.0. USER SCREENS

Four user screens display TED data, permit users to enter resolution data, and provide feedback to users on the rules of resolution.

3.1. Becoming Familiar With The Screens

3.1.1. Each claim set uses multiple screens to display data. To access the different screens, users click on tabs. All sets have a CLAIM SET SCREEN and a CLAIM DETAIL SCREEN. If the set is composed of non-institutional claims, it also has a LINE ITEM DETAIL SCREEN. If the set has associated TED adjustments, the set also has an ADJUSTMENT DETAIL SCREEN.

3.1.2. Normally, the first screen to be displayed will be the CLAIM SET SCREEN. This screen reflects the current date and labels the set as either an institutional or non-institutional set. The top section of the screen contains the menu bar for initiating a number of user functions. Below the menu bar, in the upper portion of the screen, are the Set Number, Status, Match Type, Owner FI, Owner Region, and Set Level User Defined Code fields. Totals of individual claim recoupment amounts are also displayed in the upper section. In the lower portion of the screen, claim-level data extracted from TEDs are displayed. The lower portion also contains fields for indicating which claims are duplicates, reason codes, the amounts to be recouped *and the amounts actually recouped* for each duplicate claim. In addition, fields for entering claim level user defined codes are available as well as a "solicited" field that may be used to distinguish duplicates for which refunds must be solicited from those for which only a TED adjustment *is* required.

3.1.3. At the bottom of the CLAIM SET SCREEN is a ***Detail*** tab which allows the user to move to the CLAIM DETAIL SCREEN. Once in the CLAIM DETAIL SCREEN, the user can click on a ***Set*** tab to move back to the CLAIM SET SCREEN.

3.1.4. The top portion of the CLAIM DETAIL SCREEN contains set information. Below the set information, claim-level detailed data are displayed. Note that left and right arrows and a scroll bar appear on the bottom of the data box to allow the user to scroll through this data. Approximately 50 claim-level fields are shown for each claim.

3.1.5. If a claim set contains non-institutional claims, there will be a ***Line Item*** tab at the bottom of the CLAIM SET SCREEN and the CLAIM DETAIL SCREEN to allow the user to move to the LINE ITEM DETAIL SCREEN.

3.1.6. Note that the LINE ITEM DETAIL SCREEN has a sort function above the line item data fields. The black dot in the diamond to the left of the **Unsorted** label indicates that the display is in *Internal Control Number (*ICN*)* order (i.e., all line items from one claim are shown before the next claim's line items). If the display contains more than two line items, it may be helpful to sort the display by grouping matched line items. To sort the line items by procedure code, the user clicks *on* the ***SORTED*** *button just* to the left of the ***UNSORTED*** *button*.

3.1.7. If a claim set has any adjustments corresponding to institutional claims or non-institutional line items, there will be an ***Adjustment*** tab at the bottom of all screens. This tab allows the user to move to the ADJUSTMENT SCREEN.

3.1.8. The bottom portion of the ADJUSTMENT SCREEN displays data for each adjusted claim. A vertical scroll bar will appear when appropriate to allow the user to view additional adjustments. Like all DCS system screens, the ADJUSTMENT SCREEN displays TED data. Adjustment data displayed includes claim ICN, TED line item and procedure code, and the paid amount of the adjustment.

3.1.9. All screens were designed to display relevant information to facilitate set resolution. Note that claims data is color-coded so that:

3.1.9.1. Extracted data from the TED database and claim-specific data created by the system appear in black.

3.1.9.2. The total amounts calculated by the system appear in red.

3.1.9.3. Data in user-controlled fields appear in blue or green.

3.1.9.4. ICNs which represent claims in multiple sets appear in white on the CLAIM SET SCREEN.

As explained in the preceding paragraphs, user screens have been designed to display claims data and associated adjustments and also provide for user entry of information needed to resolve the set. User screens also display information about the set, showing the Set Number, Set Status, Match Type, Owner FI, and Owner Region.

All screens display ***VCR*** movement buttons on the bottom of the screen to enable a user to move to another screen of the same set or to move to the first, next, previous, last, or a user designated set contained within the contractor's full or restricted "view." A contractor will have full view of all the sets for which the contractor has been assigned as the **Owner FI** if no restricted views (via the **V**iew function of the menu bar) have been set by the contractor. If, however, the contractor uses the **V**iew function to request a restricted view of, for example, only *Pending* institutional sets with an exact match, the contractor will see only those sets. (See paragraph 4.1.2., for a description of the **V**iew function of the menu bar.)

There are four screens that display information about a set:

- CLAIM SET SCREEN
- CLAIM DETAIL SCREEN

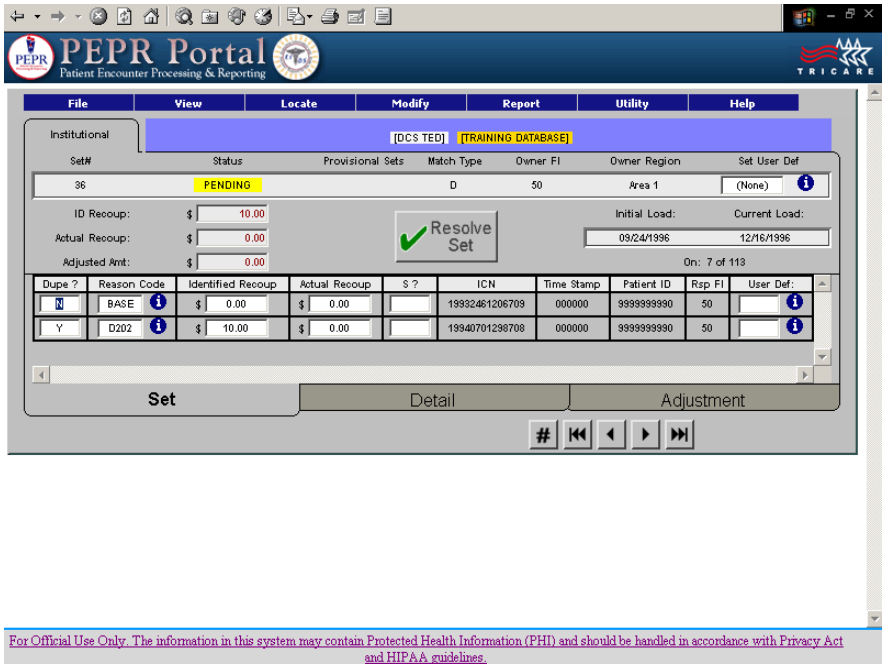
- LINE ITEM DETAIL SCREEN (Non-institutional sets only)
- ADJUSTMENT SCREEN (Sets with adjustments)

3.2. Claim Set Screen

3.2.1. Set-Level Portion Of The Claim Set Screen

The CLAIM SET SCREEN displays general information about the claim set and the individual claims within the set. It is considered to be the first screen in each set. As shown in Figure 10-5-1, this screen displays system-calculated totals of the amount identified for recoupment, amount actually recouped, and the adjustment amount. Note that these totals are calculated from the entries the user made in the claim level portion of the screen. The screen also displays the set number, the set status, the set **Match Type**, the **Owner FI**, and the **Owner Region**. It also displays the initial and current load dates and the set count of the current set versus the total number of sets in the contractor's full or restricted view of the sets, e.g., "53 of 3333", meaning the current set is the 53rd set of a total of 3,333 sets in the current view.

FIGURE 10-5-1 SAMPLE CLAIM SET SCREEN



3.2.2. Set Level User Defined Field

The upper portion of the screen also contains the **Set User Def** field. This field permits users to enter a user defined code to label the set to reflect additional information that the contractor wishes to track or to have available. While users may enter a user defined code, only certain contractor users have permission to define, activate, or de-activate the codes that may be used. User defined codes may be one or two characters in length. (See paragraph 4.2.1., for additional information.)

3.2.3. RESOLVE And UNRESOLVE Buttons

The screen also contains the **RESOLVE THE SET** button if the set is in *Open* or *Pending* status or the **UNRESOLVE THE SET** button if the set is in *Closed* or *Validate* status.

3.2.4. Set Recoupment Amounts

As noted above, the system-calculated totals of the amounts identified for recoupment, amounts actually recouped, and adjustment amounts for this set are based on the entries made by the user in the claim-level portion of this screen, the LINE ITEM SCREEN (for non-institutional sets) and the ADJUSTMENT SCREEN.

3.2.5. Claim Level Portion Of The Claim Set Screen

The claim level portion of the CLAIM SET SCREEN has headers that read: **Dupe?**, **Reason Code**, **Identified Recoup**, **Actual Recoup**, **S?, ICN**, ***Time Stamp, Patient ID***, **Rsp FI, and User Def:**. Of these *10* fields, six are designated as user entry fields and *four* are designated as read-only TED data fields. Specifically, the user-entry fields provide for entry of a 'Y' or 'N' in the **Dupe?** field to indicate if the claim is an actual duplicate payment or a non-duplicate, along with a valid reason code to explain why this determination was made. It also provides for user entry of specific claim recoupment activity to indicate the amount identified for recoupment *(for institutional sets)* and the amount actually recouped for each claim identified as an actual duplicate payment. The **Dupe?**, **Reason Code**, **Identified Recoup**, and **Actual Recoup** fields are required fields (when appropriate). The **S?** (Solicited Indicator) and the **User Def:** (User Defined Code) fields are optional.

NOTE: On non-institutional claims, entering a 'Y' in the **Dupe?** field on the CLAIM SET SCREEN, automatically triggers a system entry of 'Y' in the **Dupe?** field for each line item associated with that claim on the LINE ITEM SCREEN. The system also automatically populates the **Identified Recoup** field for each 'Y' line item on the LINE ITEM SCREEN with the **Govt Paid Amount**. The system will then enter the sum of the **Identified Recoup** amounts from the LINE ITEM SCREEN into the **Identified Recoup** field on the CLAIM SET SCREEN for that claim. Finally, the system will enter the sum of the claim level **Identified Recoup** amounts in red in the **ID Recoup** field in the upper portion of the CLAIM SET SCREEN. Users have the option of entering individual 'Y' indicators in the **Dupe?** field on the LINE ITEM SCREEN and of changing the individual line item **Identified Recoup** amounts for each line item. The system recognizes these changes and reflects them in the sums appearing on the CLAIM SET SCREEN.

3.2.6. Claim Level Data

The fields in the claim level data portion of the CLAIM SET SCREEN are described below:

- **Dupe?** (Dupeflag) - must be 'Y' for an actual duplicate or 'N' for a non-duplicate

- **Reason Code** - must be a valid reason code for the 'Y' condition (e.g., erroneous dupe override, jurisdictional error) or the 'N' condition (e.g., twins, different service)

- **Identified Recoup** - amount identified for recoupment

- **Actual Recoup** - amount actually recouped

- **S?** - Solicited Indicator. An optional use field that may be used to distinguish duplicate claims for which refunds must be initiated (solicited) as opposed to those for which refunds have been received without recoupment efforts (unsolicited refunds) or received but for which no TED adjustments have been submitted.) *It may also be used to designate the record as a "TED Dupe" in which no payment was actually made and for which a TED adjustment must be submitted.* A user may enter a 'Y', an 'N', or leave the field blank. (See paragraph 4.2.3. for additional information.)

- **ICN** - the *Internal Control N*umber

- ***Time Stamp*** *- the claim time stamp*

- ***Patient ID*** - *Patient Identifier* Number

- **Rsp FI** - The contractor responsible for this claim (either the **Processing FI** who remains currently responsible for correcting any errors associated with the claim or another contractor who, as a result of a contractor transition, is currently responsible for this claim). The **Responsible FI** for each claim may or may not be the same as the **Owner FI**. Refer to paragraph 1.1., for further explanations of these fields and *Section 7,* for information regarding mass changes.

- **User Def:** - claim level user defined field. The claim level portion of the screen also contains *a* **User Def:** field. This field permits users to enter a user defined code to label a claim to reflect additional information that the contractor wishes to track or to have available. While users may enter a user defined code, only certain contractor users have permission to define, activate, or de-activate the codes that may be used. User defined codes may be one or two characters in length. (See paragraph 4.2.2., for additional information.)

It should be noted that the *DCS* defines a "claim" as an ICN plus a unique time stamp. This is important, since two claims with the same ICN but with different time stamps may appear as potential duplicates of each other in a claim set.

3.2.7. Action And Movement Buttons And Tabs

Each screen contains several buttons and tabs that allow a user to move from set to set and screen to screen, and also to change the status of a set.

3.2.7.1. The **RESOLVE THE SET** button allows the contractor to invoke the rules of resolution to determine if the set can be resolved to a *Closed* or *Validate* status. If the set is already resolved, the button will read "UNRESOLVE THE SET". In this situation, the button can be used to unresolve the set to a *Pending* or *Open* status.

3.2.7.2. The **UPDATE CHANGES** button allows a contractor to update the Duplicate Claims *d*atabase with newly entered data. It is a "smart" button in the sense that it only appears after new data has been entered on either screen. The status of a set may change from *Open* to *Pending* or from *Pending* to *Open* when the **UPDATE CHANGES** button is pressed depending on the newly entered data.

3.2.7.3. Screen movement tabs allow a user to navigate among the four DCS screens. For example, the ***Detail*** tab allows the user to move to the CLAIM DETAIL SCREEN. Two of the screen movement tabs will appear on every set (***Set*** tab and ***Detail*** tab). The other two tabs will appear as appropriate. The ***Line Item*** tab will appear only on sets containing non-institutional claims. The ***Adjustment*** tab will only appear when an adjustment has been loaded to the set. The appearance of the ***Adjustment*** tab notifies a user that associated adjustments exist for this set and enables the user to move to the **ADJUSTMENT SCREEN** to see them.

3.2.7.4. **VCR** buttons are shown at the bottom of all screens. They allow the user to move from one set to another set, e.g., to the previous set, to the next set, to the last set. The < button moves to the previous claim set, the > button moves to the next claim set, the |< button moves to the first claim set, and the >| button moves to the last claim set available to the user. The # button, when pressed, prompts the user to enter a specific set number. When entered and the **OK** button is pressed, the user will be taken to the set specified.

3.3. Claim Detail Screen

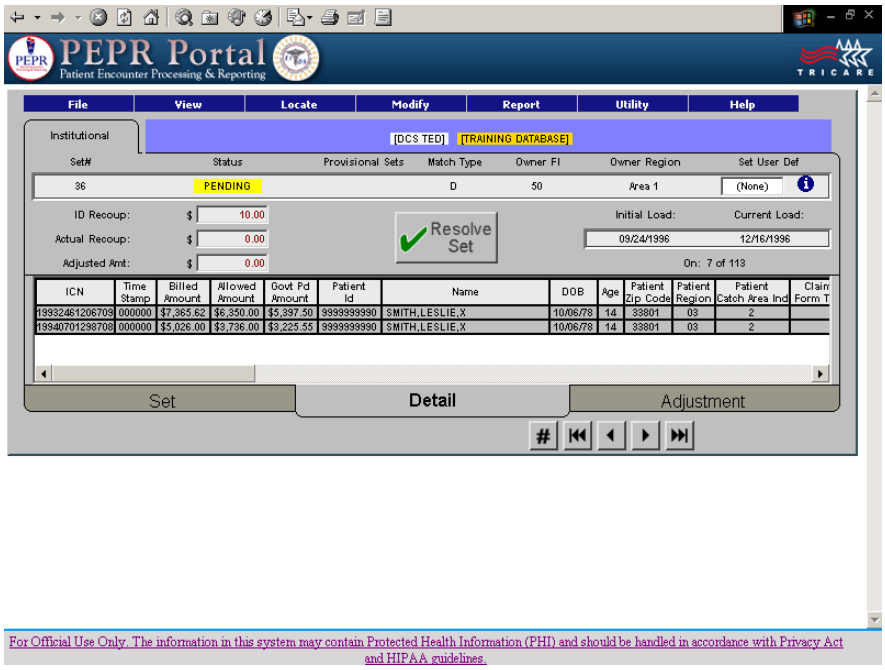
This screen displays additional TED data about each claim in the claim set. With the exception of the set level user defined field (**Set User Def**), no data may be changed and no data is entered on this screen. The data displayed is "read-only" and is provided to assist contractors in the research process. The CLAIM DETAIL SCREEN shown in Figure 10-5-2, displays 5*6* fields of TED and *DCS* data. This screen shows the following fields for institutional and non- institutional claims in a claim set:

ICN	Time Stamp
PTC Date	Sponsor ID
Patient Name	Patient ID
Patient Zip Code	Patient Date of Birth
PNT Health Services Region Code	Enrollment Code
Amt Allowed	Amt Billed
	Govt Paid
Inst Special Processing Code I	Inst Special Processing Code II
Inst Special Processing Code III	Inst Special Proessing Code IV
Special Rate Code	Inst Provider Tax ID
Inst Provider Sub ID	National Provider ID
Inst Provider Group NPI	Inst Provider Zip Code

Inst Provider Network Status Ind.
Claim Form Type
Admission Date
Inst Begin Date of Care
DRG
Batch Sequence Number
Cycle Number
Processing Contract Number
Responsible Contract Number
Risk Indicator
Reason Code
Claim Level User Def Code
Actual Recoup Amt
Dupe Flag Indicator
Patient Age
Inst Provider Health Services Region Code
Inst Provider Catchment Services Indicator
Type of Institution
Bill Frequency
Patient Disposition
Inst End Date of Care
Principal Diagnosis
Voucher Sequence Number
Processing FI
Responsible FI
Mass Change Level
Claim Match Type Code
Solicited Indicator
ID Recoup Amt
Adjustment Paid Amt
Sponsor ID Type Code
Patient Catchment Area Indicator
Provisional Indicator

Because all of these fields cannot be displayed across the width of one screen, the system provides a scroll bar and left and right arrow buttons at the bottom of the window to permit viewing all of the fields available.

FIGURE 10-5-2 SAMPLE CLAIM DETAIL SCREEN



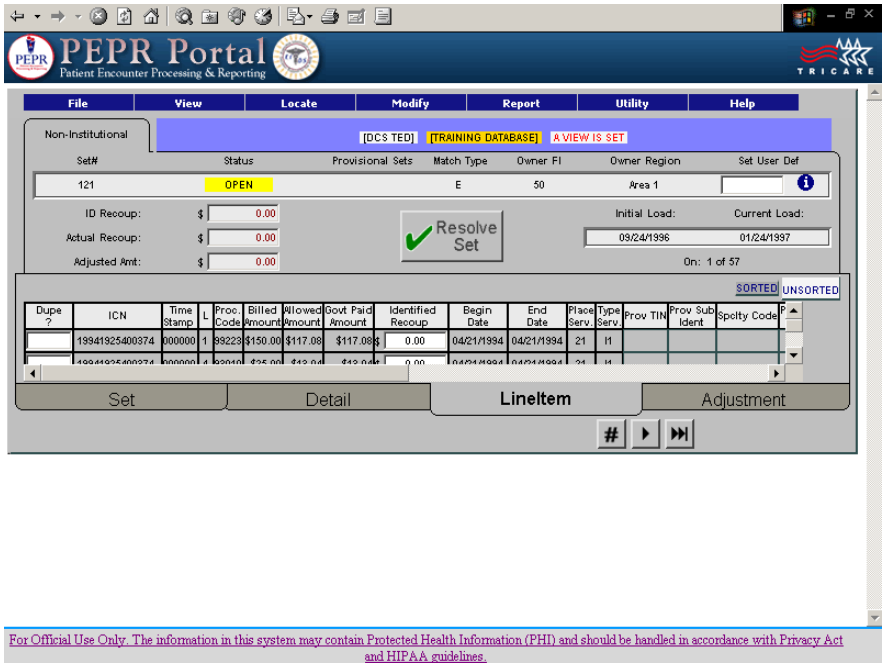
3.4. Line Item Detail Screen

This screen displays additional details about each non-institutional line item in the claim set. The LINE ITEM DETAIL SCREEN shown in Figure 10-5-3 displays, along with set information common to all screens, *33* fields containing the following line item information about each potential duplicate line item in the set:

Dupe Flag Indicator	ICN
Line Item Number	Line Item Match Type Code
Procedure Code	Place of Service Code
Type of Service Code	Service Begin Date
Service End Date	Proc Billed Amount
Proc Allowed Amount	Proc Govt Paid Amount
ID Recoup Amount	Ninst Provider Tax *Nbr*
Ninst Provider Sub-ID	Ninst National Provider ID
Ninst Provider Group NPI	Ninst Provider Zip Code
Ninst Provider Specialty	Ninst Provider Network Status Ind
Enrollment Code	*Provider Health Services* Region *Code*
Ninst Special Processing Code I	Ninst Special Processing Code II
Ninst Special Processing Code III	Ninst Special Processing Code IV
Pricing Code	*Time Stamp*
Provider Catchment Area Ind	*CPT-4 Modifier 1*
CPT-4 Modifier 2	*CPT-4 Modifier 3*
CPT-4 Modifier 4	

This screen also *offers* two *selection links* just above the line item information that are used for sorting (i.e., by procedure code) or for unsorting (i.e., by ICN) the line items displayed. Sorting may be helpful when there are more than two line items in the set. As with the data displayed on the CLAIM DETAIL SCREEN, the data on the LINE ITEM DETAIL SCREEN are extracted from the TEDs and all but two (**Dupe?** and **ID Recoup**) are read-only fields which cannot be modified. They are displayed in the LINE ITEM DETAIL SCREEN to provide additional information about each line item in the set in order to facilitate contractor research.

FIGURE 10-5-3 SAMPLE LINE ITEM DETAIL



3.5. Adjustment Screen

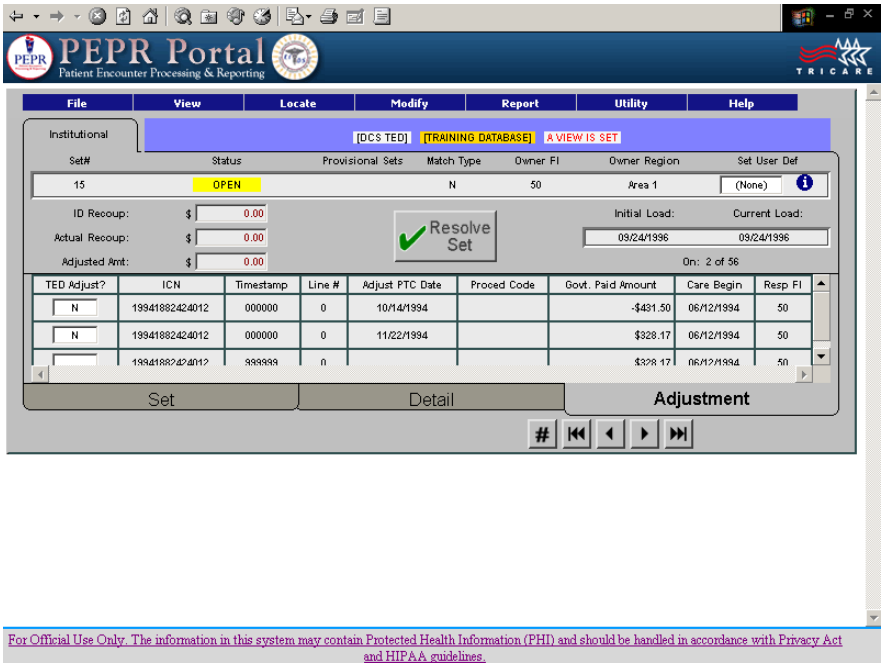
This screen displays associated TED adjustments for each institutional claim or non-institutional line item in the claim set. It also provides for user entry of a 'Y' or 'N' in a flag field to indicate which adjustment(s) are associated with the recoupment(s) of actual duplicate payments.

The ADJUSTMENT SCREEN displays the following TED data and *DCS* data fields:

TED Adjust Flag
ICN
Adjustment PTC Date
Govt Paid Amount
Responsible FI
Time Stamp
TED Line Item Number
Procedure Code
Care Begin Date

An ADJUSTMENT SCREEN for an institutional claim set appears in Figure 10-5-4. The ADJUSTMENT SCREEN for non-institutional claim sets (as shown in Figure 10-5-5) also displays the appropriate TED line item number and associated procedure code.

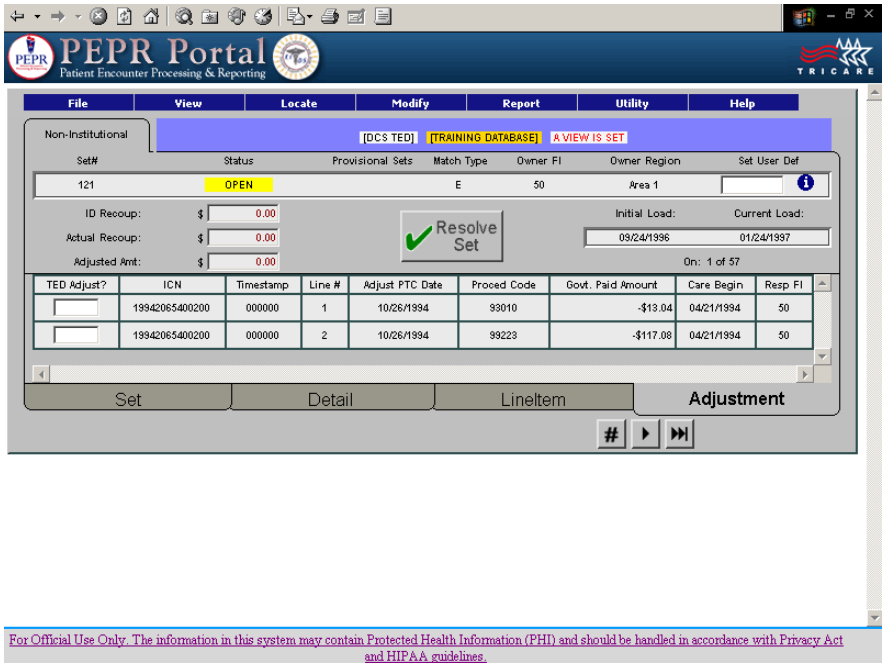
FIGURE 10-5-4 SAMPLE INSTITUTIONAL ADJUSTMENT SCREEN



The ADJUSTMENT SCREEN displays ICNs and time stamps for all adjusted claims in the set. For each adjustment, a user can view the adjustment date, the Government Paid Amount, and the **Responsible FI**. The user may enter a 'Y' in the **TED Adjust?** flag field to link the adjustment to an actual duplicate claim for which refunds/offsets have been received.

Note that for institutional claims, the procedure code will be blank. Also, the care begin date reflects the claim level begin date for institutional claim adjustments and the line item service date for non-institutional line item adjustments.

FIGURE 10-5-5 SAMPLE NON-INSTITUTIONAL ADJUSTMENT SCREEN



4.0. USER TOOLS FOR NAVIGATING AROUND THE SYSTEM

4.1. Menu Bar

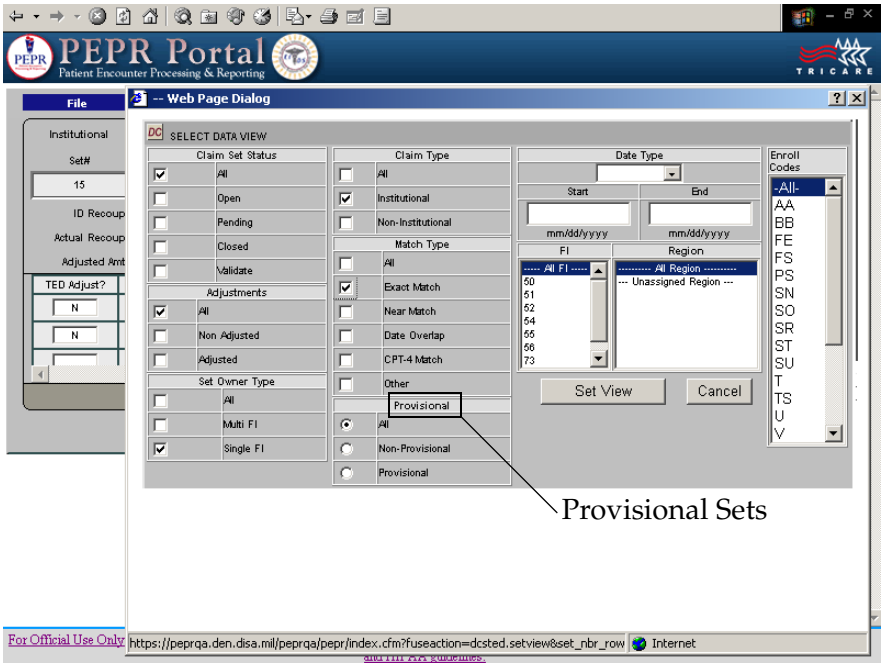
The menu bar is at the top of each screen. The menu bar contains seven selections which can be activated by a single click of the mouse.

4.1.1. File

The **F**ile function contains *two* choices: **P**rint to generate a report containing all of the data in the current set and **E**xit to return to the *ACCESS SCREEN*. Users should be aware that the **P**rint choice will display a report of the data for the current set including comments and notepad entries.

4.1.2. View

FIGURE 10-5-6 VIEW FUNCTION



The **V**iew function, shown in Figure 10-5-6, allows users to "**S**et a view", i.e., to restrict their view of claim sets which satisfy parameters defined by the user. Users can pick and choose the types of sets they wish to view by clicking on the various buttons appearing on the Select Data View parameter form. Some of the views users can create include:

- Only single contractor sets.
- Only *m*ulti-contractor sets.
- Sets associated with a specific region or contract.
- Only institutional or non-institutional sets.
- Sets selected by a specific match criteria (e.g., near match).
- Only sets in *Open*, *Pending*, *Validate*, or *Closed* status.
- Sets with adjustments or without adjustments.
- Only sets loaded during a specific month.

Additional set views may be created by clicking on two or more buttons. For example, a *West* Region or TMA user could click on the appropriate buttons and view only sets in *Open* status that meet the exact match criteria for *the West* Region.

The message "A View is Set" is displayed when a user has successfully set a view to remind the user that a restrictive view is in effect. The **V**iew function also allows users to "**C**lear a view" and return to viewing all sets available for that user.

4.1.3. Locate

The **L**ocate function provides a means for quickly finding and viewing specific sets by specifying a:

- Claim Set Number
- Claim ICN
- Sponsor ID
- Patient ID

When the user selects **L**ocate Value from the **L**ocate menu bar, a pull-down menu appears from which the user can choose a Claim Set Number, ICN, Sponsor ID, or Patient ID. Once one of the choices is selected, the user enters the desired number in a value box and clicks the **OK** button. After a few moments, the system will display the first set meeting the criteria selected.

If a user selects a specific claim set by set number on the pull-down menu (e.g., Claim Set 25), the system will display only the set with the number "25". If a user enters a specific Sponsor ID, Patient ID, or ICN, there may exist other sets in the system that contain claims with the same values. If multiple sets exist in the database that contain the same ICN, Sponsor ID or Patient ID, two options on the **L**ocate pull-down menu become active, i.e., "**L**ocate Next" or "**L**ocate Previous", allowing the user to go to the next or previous claim set containing that ICN or ID.

For example, if a user wants to see all of the sets with claims containing Sponsor ID "123456789", the user will select the "Sponsor ID" and enter "123456789" in the value box on the **L**ocate Value pull-down menu. The system will display the first set containing a claim with a Sponsor ID of "123456789". After viewing this set, the user can again select the **L**ocate function on the menu bar. If additional sets containing this ID exist in the database, the **L**ocate Next option on the pull-down menu is activated. If selected, the system will bring the second set containing Sponsor ID "123456789" into view. The user may continue to request the next claim set until no more are found in the system.

Likewise, if the **L**ocate Previous button is selected, a previous claim set containing the selection criteria will be displayed. The user may continue to request previous claims sets until no more are found in the system. The user can move between claims sets by using the **NEXT** and **PREVIOUS** options.

4.1.4. Modify

The **M**odify function enables a contractor to change the **Owner FI** field in a multi-contractor claim set or assign a contract/region to a multi-contractor claim set received from another contractor.

Each contractor will see two options in this function: **Owner FI** *(only if it is multi-FI set)* and **Owner Region** *(always)*. The **Owner FI** can select the **Owner Region** option to change the **Owner Region** assigned to the set. If the set is a multi-contractor set, the **Owner FI** also can select the **Owner FI** option to change the **Owner FI** to another contractor (**Responsible FI**). If a set is transferred to a new **Owner FI**, the new **Owner FI** must select the

Owner Region option to change the **Owner Region** from "Region Unknown" to the applicable region associated with that set.

The **M**odify function also has a **G**overnment option for a select group of TMA staff. This option is not visible to contractor users. The **G**overnment option has a **S**tatus function that allows authorized TMA users to change the status of a set. The status of a set will not be changed by a TMA user without first coordinating the change with the applicable contractor.

4.1.5. Report

The **R**eport function offers a selection of report and graph formats. See *Section 8* and Addendum E, for descriptions of the available reports and detailed instructions on using the **R**eport function.

4.1.6. Utility

The **U**tility function enables a user to:

4.1.6.1. View **M**odify FI Explanation - View (but not edit) explanations given for changing the **Owner FI** field in multi-contractor sets.

4.1.6.2. Change or View **V**alidate Explanation - View explanations entered for validate claim sets and edit these explanations.

4.1.6.3. View **R**eason Code Explanation - View (but not edit) explanations associated with certain reason codes. The system requires that certain reason codes be supported by a narrative explanation. Users are prompted for the explanation when certain reason codes are selected.

4.1.6.4. Create, Change, or View **N**otepad - The **N**otepad function provides users with the capability to attach notes or comments to a set. **N**otepad entries are made at the set level. When ownership of a set changes, **N**otepad entries are carried with the set. **N**otepad entries may contain whatever the user wishes. To create or edit a **N**otepad entry, the user should select the **U**tility function. From the drop-down menu, the user should select "Create, Change, or View **N**otepad". In the screen that appears, the user can enter or edit text or delete the note altogether.

4.1.6.5. **D**ownload - Initiate a download of data to a local PC for ad hoc query and reporting purposes.

4.1.6.6. Modify **S**et User Defined Codes - Available to and used by a limited number of users selected by each contractor to create, modify, activate, de-activate or delete Set Level User Defined Codes for that region. (See paragraph 3.2.2. for additional information.)

4.1.6.7. Modify **C**laim User Defined Codes - Available to and used by a limited number of users selected by each contractor to create, modify, active, de-activate or delete Claim Level User Defined Codes for that region. (See paragraph 3.2.6. for additional information.)

4.1.6.8. Unarchive Set - This option is only available when the user is in the History database. It may only be used by a limited number of users selected by each contractor. It allows the user to move the set from the History database to the Active database where changes to the set can be made.

NOTE: Sets that are unarchived will appear in the production database in *Closed* or *Validate* status. On a monthly basis, immediately following the monthly load process, the DCS will sweep the production database for sets that have been in *Closed* status for two years or *Validate* status for five years and will archive, i.e., move, these sets to the history database. If a user unarchives a set and does not change the status from *Closed* or *Validate* to *Open* or *Pending* immediately after unarchiving the set, there is a risk that the set will be returned to the History database.

4.1.7. Help

The **H**elp function allows the user to select **A**bout from the pull-down menu. **A**bout informs the user of the version number of the *DCS* operating on that particular PC.

4.2. User Defined Fields

The *DCS* provides contractors with three user defined fields. The purpose of these fields is to provide mechanisms for contractors to meet their own administrative and tracking needs. Two of the three user defined fields allow certain identified users to create, modify, activate, de-activate, or delete contractor defined code values (set level user defined field and claim level user defined field). The third user defined field is the "Solicited Indicator" field (**S?**). This field has three valid values, 'Y', 'N', or blank. The following describes each of these fields and their use.

4.2.1. Set Level User Defined Field

The set level user defined field is located in the upper portion of the DCS screens. This field may contain any two-character alphanumeric value that has been defined by the user. The two-character codes are unique to each region and are deleted should the set be transferred to another contractor. These user defined codes may be used for any purpose needed by the user. Codes may be useful for tracking or reporting purposes. Values may be entered in this field when user defined codes have been defined for a region and the set is in *Open* or *Pending* status. Only contractor-specified users may define set level user defined field codes.

The contractor-specified users will see the "Modify **S**et User Defined Codes" selection on the **U**tility menu. Users who do not have permission to create, modify, activate, de-activate, or delete user defined codes will not see these selections. To define a code:

- Click on the **U**tility function on the menu and select "Modify **S**et User Defined Codes." A table will appear.
- Click on the **ADD CODE** button. A new record will be added to the table and the cursor will move to the **Contractor FI #** field.

- Click on the down arrow to select the applicable Contractor FI number. Only those numbers for which the user has permissions will be available to select.

- Click on the **Contract #** field to select the corresponding contract number associated with the **Contractor FI #** that was selected in the previous step.

- Click on the **Code** field and enter the two-character code desired.

- Click on the **Code Description** field and enter a description for the code created in the previous step.

- Once the description has been entered, either accept the default of 'Y' in the **Active? (Y/N)** field or change it to 'N' if the code will be activated at a later time.

- Click *the* **OK** *button* and save the changes when prompted. *Click the* ***RETURN TO SET*** *button to* return to the CLAIM SET SCREEN.

Once codes have been defined, users can click on the *blue* ***i*** *button* on any DCS screen and a list of entered codes will appear from which to select. By clicking on a code, it will be entered into the field. Use of this field is not required. Contractors may choose to use it or not use it as they see fit. A number of reports include this field on the Report Parameter Selection Form and in the reports themselves. This field is also included in contractor initiated downloads of set data.

4.2.2. Claim Level User Defined Field

The claim level user defined field is located in the claim level portion of the CLAIM SET SCREEN. This field may contain any two-character alphanumeric value that has been defined by the user. The two-character codes are unique to each region. These user defined codes may be used for any purpose needed by the user. Codes may be useful for tracking or reporting purposes. Values may be entered in this field when user defined codes have been defined for a region and the set is in *Open* or *Pending* status. Only contractor-specified users may define claim level user defined field codes.

The contractor-specified users will see the "Modify **C**laim User Defined Codes" selection on the **U**tility menu. Users who do not have permission to create, modify, activate, de-activate, or delete user defined codes will not see these selections. To define a code:

- Click on the **U**tility function on the menu and select "Modify **C**laim User Defined Codes." A table will appear.

- Click on the **ADD CODE** button. A new record will be added to the table and the cursor will move to the **Contractor FI #** field.

- Click on the down arrow to select the applicable Contractor FI number. Only those numbers for which the user has permissions will be available to select.

- Click on the **Contract #** field to select the corresponding contract number associated with the **Contractor FI #** that was selected in the previous step.

- Click on the **Code** field and enter the two-character code desired.

- Click on the **Code Description** field and enter a description for the code created in the previous step.

- Once the description has been entered, either accept the default of 'Y' in the **Active? (Y/N)** field or change it to 'N' if the code will be activated at a later time.

- Click *the* **OK** *button* and save the changes when prompted. *Click the* ***RETURN TO SET*** *button to* return to the CLAIM SET SCREEN.

Once codes have been defined, users can click *on the blue* ***i*** *button* on the **User Def:** field on the CLAIM SET SCREEN and a list of entered codes will appear from which to select. By clicking on a code, it will be entered into the field. Use of this field is not required. Contractors may choose to use it or not use it as they see fit. A number of reports include this field on the Report Parameter Selection Form and in the reports themselves. This field is also included in contractor initiated downloads of claim data.

4.2.3. Solicited Indicator Field (S?)

The **Solicited Indicator** field is located in the lower portion of the claim set screen. It is labeled "**S?**" and follows the **Actual Recoup** field. It also appears in the CLAIM DETAIL SCREEN and is labeled "Solicited Indicator." Use of this field is optional but is recommended that contractors use it to help differentiate actual duplicates requiring recoupment from those that require only TED adjustments. A 'Y' in this field indicates that a recoupment will be initiated. A 'N' means that no recoupment action is required (e.g., a refund has already been received or a claim has already been cancelled but a TED adjustment needs to be submitted since duplicate TEDs for the claims reside on the TED database. A blank indicates undetermined.

4.3. Finding Claims in Multiple Sets

The system alerts users when a claim appears in multiple sets. When a claim appears in more than one set, the ICN appears on the CLAIM SET SCREEN in white print. If a claim does not appear in other sets, the ICN will be in black *or red* print. A user wishing to move to the next set containing the claim with the same ICN and can double click on the ICN. A dialog box will appear with Locate **N**ext and Locate **P**revious options. The user can select either option and the system will display the requested set(s).

5.0. USER ENTRY OF DATA TO RESOLVE CLAIM SETS

The *DCS* facilitates the resolution of duplicate claims by minimizing the amount of data that must be entered by users. It also provides an easy-to-use environment for data entry.

5.1. The entry of data by contractors is limited to *10* fields. Seven fields appear in the CLAIM SET SCREEN, two fields in the LINE ITEM SCREEN, and one field in the ADJUSTMENT SCREEN, as described below:

5.1.1. On the CLAIM SET SCREEN, the contractor may enter:

- 'Y' or 'N' in the **Dupe?** field [required *for institutional*]. *(**NOTE**: For non-institutional, see Section 2, paragraph 5.1.)*
- A reason code selected from lists built into the system, and a supplemental explanation where necessary (*see Addendum B*) [required].
- An identified recoupment amount for each actual duplicate identified [required for institutional sets].
- An actual recoupment amount when refunds or offsets are collected [required].
- A user defined code at the set level [optional].
- A user defined code at the claim level [optional].
- A 'Y' or 'N' in the **S?** (Solicited Indicator) field [optional].

5.1.2. On the LINE ITEM SCREEN, the contractor may enter:

- A 'Y' or 'N' in the **Dupe?** [optional *for non-institutional sets*] *(see Section 2, paragraph 5.1.1.).*
- An amount in the **Identified Recoup** field (the system will enter the Government Paid Amount here when the user a 'Y' in the **Dupe?** field. (The user may modify this amount.) [optional].

5.1.3. On the ADJUSTMENT SCREEN, the contractor may enter a 'Y' in the TED Adjustment (**TED Adjust?**) field for any claim that has an adjustment displayed on the screen. Note that the adjustment paid amount, which corrects a duplicate condition and resolves a claim set, appears as a negative number in parenthesis. When adjustments are selected in the system, the negative allowed amounts are converted to a positive value when they are added to the total **Adjust Amount** field and used by the rules of resolution to resolve claim sets.

5.2. After entering data on a CLAIM SET SCREEN, LINE ITEM SCREEN, or ADJUSTMENT SCREEN, a contractor will notice that the **UPDATE CHANGES** button appears. The contractor may click the **UPDATE CHANGES** button to see if a change in status (*Open* to *Pending* or *Pending* to *Open* only) will occur as a result of the newly entered data. Upon clicking the button, the user will be prompted to select one of the following:

- "Yes" to commit to the database the changes just made.
- "No" to rollback all the changes just made.
- "Cancel" to cancel this operation and go back to the screen.

If the user moves off a claim set after entering data (*i.e.,* by clicking one of the **VCR** buttons or by using the **V**iew or **L**ocate functions), but before clicking on the **UPDATE CHANGES** button, the changes will be automatically sent to the database and the set will be updated.

5.3. In invoking the rules of resolution by clicking on the **RESOLVE** or **UPDATE CHANGES** button, the user instructs the system to look at the values in the three total amount fields. The three total amount fields are:

5.3.1. Total Amount Identified for Recoupment (**ID Recoup**), computed from the sum of the amounts the user enters at the claim level on the CLAIM SET SCREEN.

5.3.2. Total Amount Actually Recouped (**Actual Recoup**), computed from the sum of the amounts the user enters at the claim level on the CLAIM SET SCREEN.

5.3.3. Total TED Adjustment Paid Amount (**Adjust Amount**), computed from the sum of TED paid amounts on the adjustments flagged with a 'Y' in the TED Adjustment (**TED Adjust?**) field on the ADJUSTMENT SCREEN.

The system subjects the totals in these three fields to the rules of resolution and determines if other data elements entered by the user satisfy the rules of resolution for a *Closed* or *Validate* claim set status. See *Section 2, paragraph 5.0.,* for a description of the rules governing the resolution of claim sets in the system, and *Section 4, Figure 10-4-1,* for a flow diagram of these rules.

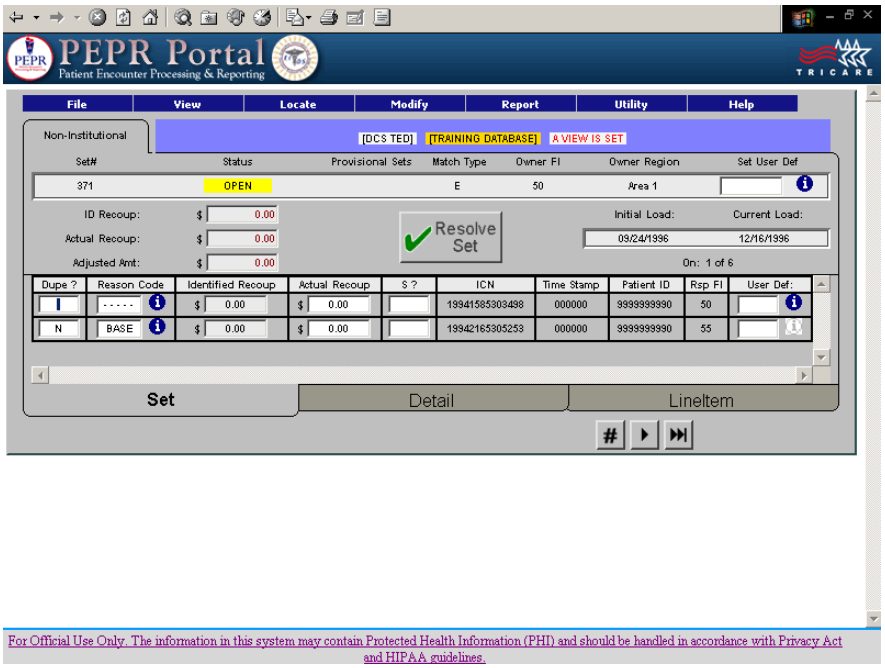
MULTI-CONTRACTOR CLAIM SETS

On occasion, two different contractors will pay for the same billed services. These types of duplicate payments are a result of jurisdictional processing errors. To ensure that this type of duplicate payment is addressed in the Duplicate Claims System *(DCS)*, special data fields and procedures have been incorporated.

1.0. DESCRIPTION OF A MULTI-CONTRACTOR CLAIM SET

A multi-contractor claim set contains potential duplicate claims processed by two or more contractors. A multi-contractor set, consisting of **Responsible FI**s *50* and *55*, is shown in Figure 10-6-1. The resolution of multi-contractor claim sets requires coordination between/among the contractors involved. Multi-contractor sets always involve an erroneous payment because only one contractor is responsible for processing and paying for services within a jurisdiction at any given time. When two different contractors pay for the same billed service, it means that one or more of the claims in the set were erroneously processed and paid by a contractor who did not have processing jurisdiction.

FIGURE 10-6-1 SAMPLE MULTI-CONTRACTOR CLAIM SET



As with all other potential duplicate claim sets, the *DCS* assigns ownership of each set, i.e., responsibility for resolving the set, to the contractor who submitted the claim with the latest processed to completion *(PTC)* date. This contractor becomes the **Owner FI**, who

must research the claims in the set to determine if they had jurisdiction for the billed services. If the assigned **Owner FI** determines that they did not have processing jurisdiction for the claims in the set and, therefore, paid the claims in error, the **Owner FI** must resolve the duplicate situation. This means that the **Owner FI** must remain as the **Owner FI**, indicate that a duplicate condition exists in the set, initiate recoupment of the overpayments, ensure receipt of the refunds/offsets, submit appropriate *TRICARE Encounter Data (*TED*)* adjustments, verify that these adjustments are reflected in the TED database, and resolve the set.

If, however, the **Owner FI** determines that they did have processing jurisdiction for the claims in the set and, therefore, the other contractor paid the claim(s) in the set in error, the current **Owner FI** must change ownership of the set to the other contractor for resolution.

Changing set ownership (i.e., the **Owner FI** field) is a function limited to multi-contractor sets. Ownership of other duplicate claim sets cannot be changed by a contractor. Only multi- contractor sets can be changed. The **Owner FI** change is restricted to the contractors (**Responsible FI**s) that processed claims in the set or are responsible for claims transferred in a contract transition. See *Section 7,* for more details about contract transitions.

When ownership of a multi-contractor claim set is changed, the set is moved from the view of the old **Owner FI** to the new **Owner FI**. The new **Owner FI** becomes the new "owner" of the set and assumes responsibility for resolving the duplicate situation in the set. The old **Owner FI** uses the **M**odify function on the menu bar to re-assign ownership of the claim set to the other contractor.

The system uses three fields to manage the assignment of responsibility for resolving duplicate claims in multi-contractor claim sets. By default, the system assigns the **Owner FI** field to the contractor that processed the claim with the latest *PTC* date. Multi-contractor claim sets appear along with all other claim sets assigned to the same **Owner FI**. Other contractors will not have access to these sets.

The **Responsible FI** field is used to identify the contractor who is currently responsible for a claim. This field is shown for each claim listed on the CLAIM SET SCREEN and the CLAIM DETAIL SCREEN. The **Processing FI** field is used to identify the contractor that paid the claim. This field is shown on the CLAIM DETAIL SCREEN. These fields are described below.

1.1. Owner FI Field

This field is assigned by the *DCS* to each claim set. The **Owner FI** field designates the contractor responsible for resolving the claim set.

1.2. Responsible FI Field

This field is assigned by the *DCS* to each claim in a set to identify the contractor responsible for correcting any errors in the claim and for recouping any overpayments of actual duplicate payments. The **Responsible FI** of the claim with the latest *PTC* date is also assigned as the **Owner FI** of the set. During a contract transition, the system looks at all claims belonging to the outgoing contractor and determines if the **Responsible FI** field

should be changed to the incoming contractor. If the claim is included in the transition plan, the system will change the **Responsible FI** field to the incoming contractor or to the inactive designation of FI 99. The FI 99 designation will appear on the screen in red. If the claim is not included in the transition plan, the system will leave the field unchanged. See paragraph 5.0., for additional information.

1.3. Processing FI Field

This field is a claim-level data element that is extracted from the TED. It contains the FI number of the contractor that originally processed the claim. The **Processing FI** field cannot be changed in the *DCS*.

2.0. SYSTEM FEATURES UNIQUE TO MULTI-CONTRACTOR CLAIM SETS

The layout of the data and the screens available for viewing and entering data in multi-contractor claim sets is the same as the layout of single contractor claim sets. In multi-contractor sets, though, the contractor who is designated the **Owner FI** can change the **Owner FI** field to designate the other contractor as the **Owner FI**. This process is initiated as follows:

2.1. Click on the **M**odify function on the menu bar.

2.2. Click on the **Owner FI** option from the drop-down menu.

2.3. The system displays the FI number(s) of the other contractor(s) in the set. Click on the contractor to be designated as the new **Owner FI**.

2.4. This feature also requires the current **Owner FI** to document contact with the contractor to which the set will be transferred and provide an explanation for why ownership of and responsibility for resolving the set is being changed. When a new **Owner FI** is assigned, the **Owner Region** field changes to "<to be assigned>". The new **Owner FI** subsequently can click on the **M**odify function, **Owner Region** option, and select the appropriate **Owner Region**.

A system feature unique to multi-contractor sets is the rule for changing the status of a set to *Pending*. In effect, the system ignores the claims in the set in which the **Responsible FI** is not the **Owner FI**. It allows an **Owner FI** to move a set to a *Pending* status if there is one BASE claim and all of the **Owner FI**'s claims meet the general conditions for *Pending* status. That is, all **Owner FI** claims must have a dupeflag and reason code, there must be a 'Y' claim, and every 'Y' claim must have an identified recoupment amount greater than $0.00. According to this rule, the status of a multi-contractor set may change as the **Owner FI** changes. For example, if the **Owner FI** identifies all of their claims as actual duplicates and enters a 'Y' in the **Dupe?** fields, selects reason codes and enters amounts identified for recoupment, and leaves the other contractor's claim as the BASE claim, and clicks the **UPDATE CHANGES** button, the status of the set will move to *Pending*. However, if the **Owner FI** changes the **Owner FI** field to the other contractor that has only the BASE claim, the new **Owner FI** will receive the set in *Open status*. According to the rules, the new **Owner FI** does not have actual duplicate claims with associated amounts identified for recoupment. Since *Pending* status means pending recoupment and since the new **Owner FI**'s claim is the

BASE claim and is not one of the duplicates, the set cannot be pending recoupment for the new **Owner FI**. The set would be in *Pending* status for the old **Owner FI** not the new **Owner FI**.

2.5. Another system feature unique to multi-contractor claim sets is the special logic invoked for multi-contractor appended sets. When a new claim is identified during the monthly extract as a potential duplicate of a claim in an existing set, the set is called an appended set. In appending a new claim to a set, the system applies the general rule of assigning the **Owner FI** to the **Responsible FI** of the claim with the latest *PTC* date if the status of the set is *Open* or *Closed*. If the status of the set is *Pending* or *Validate*, the system ignores this rule and leaves the current assignment of the **Owner FI**. The system also applies special logic to determine the status of multi-contractor appended sets.

The status of multi-contractor sets with an appended claim is determined as follows:

- *Open* sets will remain *Open* because recoupment had not been initiated on the set prior to the new claim being appended.
- *Pending* sets will remain *Pending* to allow the **Owner FI** to complete recoupment of actual duplicate payments prior to determining if additional research is required or if the set should be transferred to another contractor.
- *Validate* sets will be changed to *Pending* to allow the **Owner FI** to determine if the appended claim changes the *Validate* situation prior to determining if additional research is required or if the set should be transferred to another contractor.
- *Closed* sets will be changed to *Open* to allow the **Owner FI** to determine if the appended claim requires additional research or if the set should immediately be transferred to another contractor.

3.0. COORDINATION REQUIREMENTS WHEN WORKING WITH MULTI-CONTRACTOR SETS

Resolution of multi-contractor claim sets requires close coordination between the contractors involved to ensure that research efforts and resolution activities are conducted efficiently, appropriately, and in a timely manner. When researching a multi-contractor set, the **Owner FI** must coordinate with the other contractor(s) involved to determine who is responsible for the duplicate payment(s) and for recouping the overpayment(s). The method of coordination must be negotiated between contractors and may take whatever form is agreeable, i.e., by telephone, fax, e-mail, or combination thereof. This coordination is a courtesy among contractors and should prevent indiscriminate transfers of sets back and forth. If the current **Owner FI** is not responsible for the duplicate payment, the current **Owner FI** should contact the other contractor to advise them of the set, its upcoming transfer, and to discuss or describe the circumstances involved. Ownership of the set must not be changed to another contractor until the receiving contractor has been consulted and an explanation has been entered into the system justifying the switch.

The explanation entered into the system must contain:

- The date the other contractor was contacted.
- The name and telephone number of the person making the contact from the current **Owner FI.**
- The name and telephone number of the person contacted at the contractor to which ownership of the set is being changed.
- A brief explanation for the change of ownership (e.g., "This claim falls within the jurisdiction of Region 13. Contractor for Region 14 paid claim in error and is responsible for recoupment of the overpayment.").

4.0. RESOLVING MULTI-CONTRACTOR CLAIM SETS

Multi-contractor claim sets are resolved in the same manner as all other claim sets in the *DCS*.

4.1. When the initial **Owner FI** conducts research and determines that they were responsible for the duplicate payment, the contractor can initiate recoupment and resolve the claim set in accordance with the rules of resolution.

4.2. When the initial **Owner FI** determines that the duplicate payment belongs to a different contractor, the current **Owner FI** must contact the other (receiving) contractor and discuss or describe the situation before the current **Owner FI** can change ownership. The current **Owner FI** must document the contact and the reason for the change in set ownership. Although the current **Owner FI** may enter a 'Y' in the **Dupe?** field of the other contractor's claim, it is recommended that this action be reserved for the **Responsible FI** of the claim. The **Owner FI** transferring the set may not enter an amount identified for recoupment for the other contractor's claims.

4.3. After documenting the contact and agreement to change set ownership, the current **Owner FI** may change ownership to the other (receiving) contractor. Once ownership is changed in the system, the receiving contractor (the new **Owner FI**) can view the set, initiate recoupment action, and resolve the claim set in accordance with the rules of resolution. Multi-contractor sets must not be resolved without communication and coordination among the involved contractors. *The only exceptions to this are multi-contractor sets in which the only other contractor involved is FI 99.*

4.4. If a multi-contractor set contains a BASE claim and two or more additional claims processed by different contractors, ownership must be transferred to each contractor responsible for the non-BASE claims in order to resolve the set. Each contractor is responsible for identifying their duplicate payments, initiating recoupments, and submitting TED adjustments corresponding to their refunds and offsets. The set cannot be resolved unless all resolution requirements have been met.

4.5. Ownership of multi-contractor sets may switch back and forth between contractors as research is conducted and determinations about jurisdictional responsibility are made.

When a set changes ownership, only the current **Owner FI** can view the set, including all adjustments. The current **Owner FI** is never permitted to enter recoupment amounts in the other contractor's claim. The current **Owner FI** is, however, permitted to flag an adjustment submitted by another contractor to facilitate resolution.

5.0. RESOLVING CLAIM SETS CONTAINING INACTIVE FI 99 CLAIMS

Section 7, describes how the transition plan will determine if an outgoing contractor's claim should be transferred to the incoming contractor or to an inactive status of FI 99. If a claim in a multi-contractor set is transferred to FI 99, special logic is applied to the resolution of the set. The system will not permit a multi-contractor set to have an **Owner FI** of 99. Therefore, if the **Responsible FI** on the claim with the latest *PTC* date is FI 99, the **Owner FI** will be assigned to another **Responsible FI**.

The resolution of multi-contractor sets normally requires **Owner FI**s to identify at least one actual duplicate claim in the set. However, special logic is applied to multi-contractor sets containing an inactive FI 99 claim. If there are no other active contractors in the set, the **Owner FI** can resolve the set without identifying an actual duplicate claim. In other words, if the **Owner FI** is the **Responsible FI** of one claim in the set and the other claim has a **Responsible FI** of 99, the **Owner FI** can identify both claims as non-duplicates and resolve the set to a *Closed* status. The **Owner FI** also can resolve sets containing FI 99s according to the general rules of resolution in which actual duplicates are identified, recoupments are received, and adjustments are processed.

Sets with FI 99 claims are simply another type of multi-contractor set. When confronted with an FI 99 set, the **Owner FI** needs to determine if it had jurisdiction for the claim(s) it paid. For FI 99 sets the **Owner FI** should enter an 'N' in the **Dupe?** fields and enter either "BASE" or "N300" in the **Reason Code** fields of the FI 99 claims. For the **Owner FI**'s claims, an 'N' or a 'Y' may be entered in the **Dupe?** field and a valid reason code should be entered.

NOTE: An **Owner FI** claim may be designated as the BASE claim. If the **Owner FI** determines that it did not have jurisdiction for the claim(s) it paid, then it must put a 'Y' in the **Dupe?** field(s) of its claim(s).

6.0. DETERMINING JURISDICTION FOR CLAIM SETS INVOLVING "SNOWBIRD" CLAIMS

6.1. "Snowbird" claims are claims involving TRICARE Standard beneficiaries who move seasonally from one area of the country to another and tend to have two addresses. For example, a TRICARE Standard beneficiary may reside in New York for the summer months and move to Arizona during the winter. Frequently, when such beneficiaries receive health care, they will give the provider both their local address and their other residence address in the other TRICARE region. The provider may then submit a claim to the TRICARE regional contractor that covers the region in which the beneficiary currently resides showing the beneficiary's local address on the claim. The provider may then send a second claim to the TRICARE regional contractor that covers the region in which the beneficiary resides during the other part of the year showing the beneficiary's other residence address on the claim. When each contractor receives the claim, they see that the address on the claim is within their

region and they proceed to process and pay the claim. Each contractor does not know that the other has paid the same claim. When this happens, the *DCS* identifies the duplicate payments and creates a multi-contractor set. The issue in resolving these sets is determining which contractor had jurisdiction for the claim and which made the overpayment that needs to be recovered.

6.2. Since TRICARE Standard beneficiaries are by definition not enrolled, there are no enrollment records upon which regional jurisdiction can be determined. Instead, regional jurisdiction for TRICARE Standard claims processing purposes is generally based on the residence address appearing on the claim, the address residing on *Defense Enrollment Eligibility Reporting System (*DEERS*)*, and on any address information residing in the *c*ontractor's files. Beneficiaries may not have updated DEERS with what they consider to be their primary residence address. When this happens there will be discrepancies between the addresses on the claims and the address appearing on DEERS. If a beneficiary has not had any previous claims processed, there will not be any claims history available to the contractor for research. Sometimes it is not possible from existing claims or other information to determine a beneficiary's primary residence and therefore determine which contractor has jurisdiction for the claim.

6.3. As with all multi-contractor *DCS* sets, the contractors involved must communicate and coordinate with each other in order to resolve "snowbird" multi-contractor sets. The following steps shall be taken by the contractors to resolve this type of multi-contractor set.

6.3.1. The **Owner FI** of the multi-contractor set shall contact the other contractor(s) involved and advise them of the existence of the set (remember, only the **Owner FI** can see the set). In consultation with each other, if the primary address can be determined from existing information residing with the involved contractors and a decision can be made as to who has jurisdiction for the claim, then the set may be handled as any other multi-contractor set. Existing information may include previous claims history, customer service contacts (by phone, walk-in, or correspondence), DEERS address data, etc. Note that if both contractors have existing claims history and there is no other corroborating information as to the correct primary residence address, then the **Owner FI** must develop for the correct address to determine jurisdiction (see *paragraph 6.3.2.*).

6.3.2. If the primary address cannot be determined from existing information residing with the involved contractors, then the **Owner FI** shall develop for the primary residence address. Development for the primary address shall include: telephone calls to the patient, telephone calls to the provider, sending letters to the patient at both addresses requesting that the patient designate a primary address and requesting that they update DEERS with their primary residence address.

6.3.3. If none of the development efforts succeed and the primary residence address cannot be determined, the **Owner FI** shall contact the other contractor(s) involved and the contractor that processed the claim with the latest *PTC* date shall be the contractor deemed to have made the overpayment and therefore responsible for initiating recoupment. If that contractor is not the current **Owner FI** of the set, then the set shall be transferred to that contractor. In the rare event that the claims were processed on exactly the same date and at exactly the same time, the contractors, in consultation with each other, may decide which shall initiate recoupment. The actions taken and the decisions made by the contractors shall

be documented in the system either in the DCS Notepad or in the dialog box that prompts users for an explanation when transferring sets to another contractor. At a minimum, the documentation shall include the names of the people involved in the discussions from each of the contractors, the date(s), and the decisions made.

MASS CHANGE FUNCTION FOR CONTRACT TRANSITIONS

1.0. CONTRACT TRANSITIONS

When a new contract is awarded, the Government establishes a transition plan for the outgoing and incoming contractors. This plan specifies the schedule for implementing transition activities, e.g., dates when certain types of claims and encounters become the responsibility of the new contractor.

A contractor has access to and can view only those potential duplicate claim sets for which the contractor has responsibility for resolving and is the designated **Owner FI**. When a contract transition occurs, access to the duplicate claim sets must be transferred to the incoming contractor for resolution, in accordance with the transition plan. The date the incoming contractor will assume responsibility for resolving the claim sets owned by the outgoing contractor will be determined during transition meetings. The type of claim sets (e.g., financially underwritten or non-financially underwritten), that will be transferred to the incoming contractor will be determined at transition meetings. The **Responsible FI** field may be changed to an inactive FI 99 for claims that will remain the responsibility of the outgoing contractor.

For example, claim sets involving financially underwritten claims may remain the responsibility of the outgoing contractor, while non-financially underwritten claim sets may become the responsibility of the incoming contractor at some specified time during the transition period. Under the terms of the transition plan, the incoming contractor will be responsible for resolving the claim sets transferred to them from the outgoing contractor, including all recoupments and submissions of adjustment and cancellation *TRICARE Encounter Data (*TED*) record*s.

2.0. NEED FOR THE MASS CHANGE FUNCTION

When TEDs representing potential duplicate payments (along with their corresponding adjustment and cancellation TEDs) are extracted from the TED database and loaded into the Duplicate Claims *d*atabase, ownership (i.e., the **Owner FI** field) of each claim set is assigned. Additionally, a **Responsible FI** is assigned for each claim in the set. (See *Section 6, paragraph 1.2.*, for the definition of this field.) The contractor that is the **Owner FI** is responsible for resolving the set. When a contract transition occurs, responsibility for resolving a set may change. The Mass Change function manages this process by changing the **Responsible FI** field of all claims included in the transition plan. This field may be changed to the incoming contractor or to an inactive FI 99. It also may be left unchanged if the outgoing contractor remains an active contractor. The Mass Change function also changes the **Owner FI** field as appropriate.

For example, Contractor 1 has been using the Duplicate Claims System *(DCS)* for a year and the *DCS* has been extracting potential duplicates, creating claim sets and assigning ownership of these sets to this contractor. Effective, February 1, *2008*, three states are carved out of this contractor's region and a new region is established. Contractor 2 is awarded the contract for this new region. The transition plan establishes that Contractor 2 will assume full responsibility for resolving non-financially underwritten potential duplicate claim sets, previously the responsibility of Contractor 1, for these three states, on June 1, *2008*. The *DCS* will identify the affected non-financially underwritten claims and change the **Responsible FI** field of the affected claims and the **Owner FI** field of the affected sets to Contractor 2 effective June 1, *2008*.

3.0. DEFINING MASS CHANGES

The *TRICARE Management Activity (*TMA*)* is responsible for initiating the Mass Change function upon determination of the transition plan requirements pertaining to duplicate claims resolution. Mass Changes are initiated by the submission of Mass Change Specification Forms to the TMA *Automated Data Processing (*ADP*)* Facilities Management Services Contractor who is responsible for making the changes in the Duplicate Claims *d*atabase. A sample form is shown in Figure 10-7-1.

The Mass Change Specification Form lists the data fields in the Duplicate Claims *d*atabase that may be used to identify claims and claim sets whose "ownership" must be changed to accommodate a contract transition. Once a Mass Change is performed, affected claims and claim sets will be accessible to the incoming contractor and removed from the view of the outgoing contractor.

FIGURE 10-7-1 MASS CHANGE SPECIFICATION FORM

MASS CHANGE LEVEL: _____ MASS CHANGE SEQ: _____

DATA FIELD	FIELD LENGTH	VALUE
Mass Change Effective Date (DD MON YYYY format: 01 JUL 1995)	dd mmm yyyy	
Claim Set Status (Circle all affected by this change)	1	O, P, C, V, H
Claim Responsible FI (current value before Mass Change)	2	
Claim Responsible Contract (current value before Mass Change)	7	
Claim Processing FI	2	
Claim Processing Contract	7	
Beneficiary Region	2	
Provider Region	2	
Special Processing Codes	2	
Special Rate Code	2	
Financially Underwritten Indicator	1	
Provider Network Status Indicator	1	
Enrollment Code	2	
Beneficiary Zip Code Range	9	FROM: TO:
Provider Zip Code Range	9	FROM: TO:
Beneficiary Catchment Area Indicator	1	
Provider Catchment Area Indicator	1	
Processed To Completion Date Range	dd mmm yyyy	FROM: TO:
Care Begin Date Range	dd mmm yyyy	FROM: TO:
Care End Date Range	dd mmm yyyy	FROM: TO:
New Responsible FI	2	
New Responsible Contract	7	

Submitted by:_____ Date:_____
Approved by:_____ Date:_____

4.0. PERFORMING MASS CHANGES

The steps for performing a Mass Change are as follows:

4.1. The types of claims and claim sets to be transferred to a new contractor as well as the effective dates are defined in the transition plan.

4.2. These requirements are entered on the Mass Change Specification Form by TMA.

4.3. The Mass Change Specification Form is submitted to the TMA ADP Facilities Management Services Contractor at least two weeks prior to the date the change is to be effective.

4.4. The TMA ADP Facilities Management Services Contractor incorporates the mass change conditions after completion of the monthly load immediately preceding the mass change effective date.

4.5. The TMA ADP Facilities Management Services Contractor creates a report of the claims affected by the change.

4.6. TMA reviews and approves the list of claims.

4.7. Unless otherwise directed, the mass changes are thereafter applied to affected claims.

5.0. ADMINISTRATION OF MASS CHANGES

Mass changes will be strictly controlled by TMA in accordance with each contract's transition plan. See *Addendum D,* for a description of the activities and time tables that can be incorporated in a contractor to contractor transition plan.

The Mass Change function ensures that claims affected by a transition are identified and appropriately assigned. This means that the **Responsible FI** field will be changed for all claims included in the transition plan. For example, a transition plan may require that on June 1, *2008*, all non-financially underwritten claims will be transferred from the outgoing Contractor FI 75 to the incoming Contractor FI 89. At the same time, all financially underwritten claims belonging to FI 75 will be changed to an inactive designation of FI 99.

5.1. Changes To The Owner FI

The Mass Change function also determines if the **Owner FI** should be changed. The system uses the following logic to determine the **Owner FI**.

5.1.1. If the **Responsible FI** being changed is not the owner of the set, then the **Owner FI** will not change.

5.1.2. If the **Responsible FI** being changed is the owner of the set and the **Responsible FI** is being changed to an FI other than 99, and there are no other claims in the set with the same **Responsible FI** as the one being changed, then the **Owner FI** will be changed to the new **Responsible FI**.

5.1.3. If the **Responsible FI** being changed is the owner of the set and the **Responsible FI** is being changed to an FI other than 99, and there is another claim in the set with the same **Responsible FI** as the one being changed, and the claim with the **Responsible FI** being changed has an Identified Recoup amount greater than $0.00, then the **Owner FI** will be changed to the new **Responsible FI**.

5.1.4. If the **Responsible FI** being changed is the owner of the set and the **Responsible FI** is being changed to an FI other than 99, and there is another claim in the set with the same **Responsible FI** as the one being changed, and the claim with the **Responsible FI** being changed has an Identified Recoup amount equal to $0.00, then the **Owner FI** will not be changed.

5.1.5. If the **Responsible FI** being changed is the owner of the set and the **Responsible FI** is being changed to 99, and there are no other claims in the set with an FI other than 99, then the **Owner FI** will be changed to 99.

5.1.6. If the **Responsible FI** being changed is the owner of the set and the **Responsible FI** is being changed to 99, and there are other claims in the set with the same **Responsible FI** as the one being changed, then the **Owner FI** will not be changed.

5.1.7. If the **Responsible FI** being changed is the owner of the set and the **Responsible FI** is being changed to 99, and there are other claims in the set with an FI other than 99, and there are no other claims in the set with the same **Responsible FI** as the one being changed, and there are no non-FI 99 claims with an Identified Recoup Amount greater than $0.00, then the **Owner FI** will be changed to the non-FI 99 claim with the latest processed-to-completion date.

5.1.8. If the **Responsible FI** being changed is the owner of the set and the **Responsible FI** is being changed to 99, and there are other claims in the set with an FI other than 99, and there are no other claims in the set with the same **Responsible FI** as the one being changed, and there are non-FI 99 claims with an Identified Recoup Amount greater than $0.00, then the **Owner FI** will be changed to the non-FI 99 claim with an Identified Recoup Amount greater than $0.00 that has the latest processed-to-completion date.

6.0. RESOLUTION ISSUE INVOLVING TRANSITIONED SETS FOLLOWING A MASS CHANGE

During a transition, when the outgoing contractor has ceased entering refund and adjustment data on the *DCS*, refunds may be received and/or TED adjustments may still be submitted for claims in *Open* and *Pending* sets. In this case, the incoming contractor may be required to resolve the set without knowing the amount of the refund received by the outgoing contractor.

If the actual recoupment amount was zero when the set was transferred from the outgoing contractor, the incoming contractor may apply the adjustment to the set while leaving the actual recoupment amount as zero dollars. Resolution would result in a *Validate* status, requiring an explanation by the incoming contractor that the outgoing contractor did not enter the actual recoupment amount.

REPORTS

The Duplicate Claims System *(DCS)* includes an integrated reporting system that generates standard and custom reports. These reports facilitate resolution activities and support contractor and *the TRICARE Management Activity (*TMA*)* auditing and management functions. In addition to the range of user-defined reports and graphs provided by the **R**eport function on the menu bar, the system provides the capability to download data to local tables. This capability, which is accessed through the **U**tility function on the menu bar, enables users to load *DCS* data into other database management or reporting software and subsequently generate a variety of ad hoc queries and reports. See *Addendum E* for report descriptions and sample reports.

There are predefined and semi ad hoc reports and graphs available to DCS users. Each report/graph has one or two parameter screens which allow the user to refine the report by choosing specific criteria to report on. The following is a list of "standard" parameters/criteria available for each report.

The "standard" parameters (available on most reports) are:

Claim Set Status	(All, *C,* O, P, V)
Adjustments	(All, Non-Adjusted Sets, Adjusted Sets)
Set Owner Type	(All, Multi FI, Single FI)
Claim Type	(All, Institutional, Non-*I*nstitutional)
Match Type	(All, *C, D,* E, N, O)
Date Type	(Initial Load Date, Current Load Date, Last (Update) Date)
Set Range	(*B*eginning and *E*nding *S*et *N*umbers)
FI	(Select one from the list of available)
Region	(If FI selected, select one or more of available)
Exclude Base Claims	*(Check to exclude, leave blank to include)*
Solicited	*(Yes, No, Blank)*
Dupe Flag	*(Yes, No, Blank)*
Set User Codes	*(Select one or many by pressing CTRL and clicking)*
Claim User Codes	*(Select one or many by pressing CTRL and clicking)*

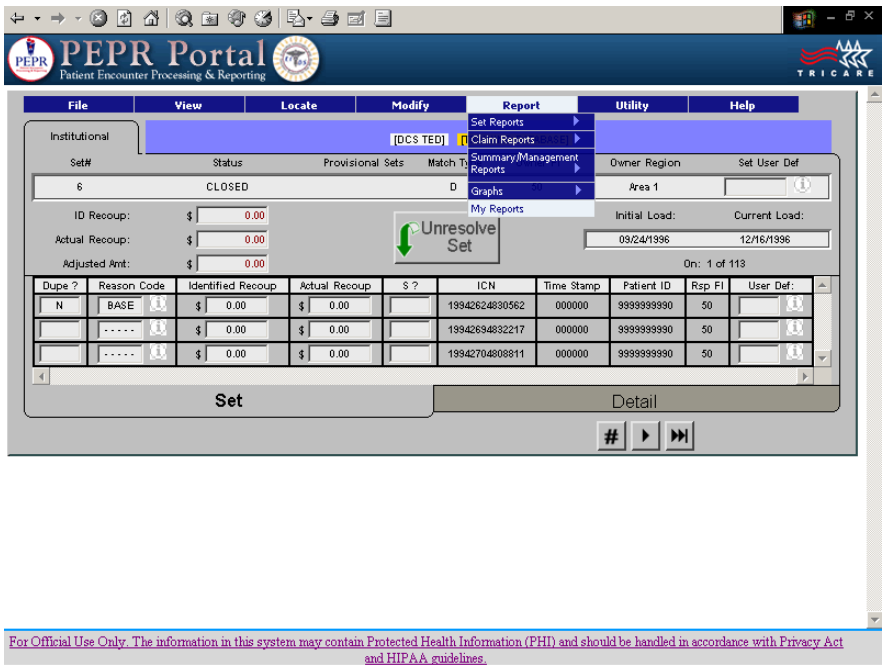
Some reports have other "special" parameters/criteria that may be selected depending on the report. (See *Addendum E* for report descriptions and available parameters.)

When a user selects a report, a Report Parameter Screen will appear. Every *REPORT PARAMETER SCREEN* will contain a **Most Common** tab on which the available "standard" parameters applicable for the selected report will be displayed. If the report has associated

"special" parameters available, a second ***S*pecial** tab will be visible. Users may further refine their report criteria from the additional parameters on the ***S*pecial** tab.

1.0. USING THE REPORT FUNCTION

FIGURE 10-8-1 REPORT CATEGORIES MENU

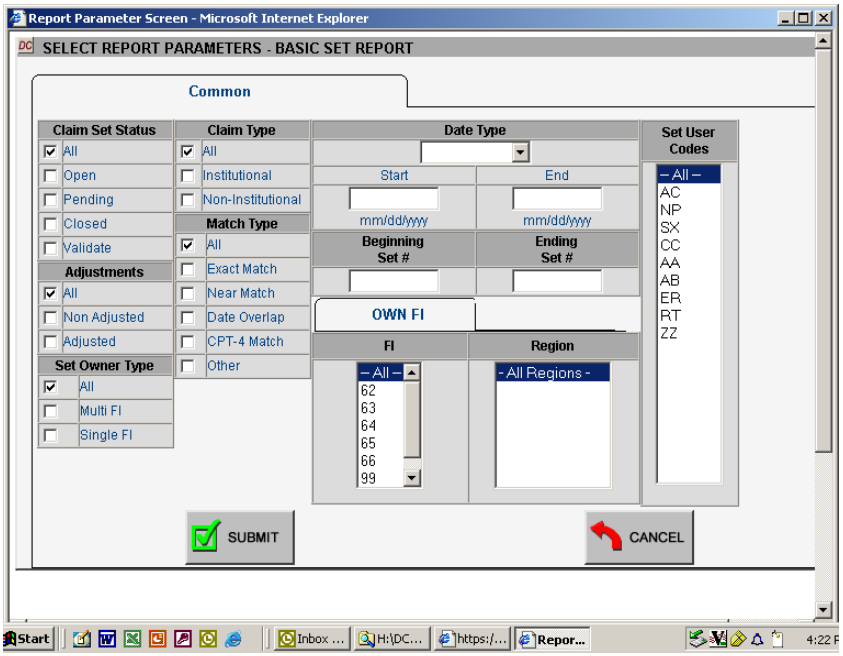


The menu bar on the top of every screen in the *DCS* includes a **R**eport function with a pull-down menu. When a user selects **R**eport from the menu bar, a report categories menu appears (shown in Figure 10-8-1) to display the four selections available to the user:

- Set Reports
- Claim Reports
- Summary/Management Reports
- Graphs
- *My Reports*

When a user selects one of the report categories, a list of the available report formats for that category appears. When a report format is selected, a parameter screen appears and presents the user with available options for limiting the sets and claims to be included in the report. The report parameter screen resembles the **V**iew screen. A number of options are presented from which the user can define the data to be included in the report. Figure 10-8-2, shows an example of options available for selecting data to be included in a report.

FIGURE 10-8-2 REPORT PARAMETER SCREEN



Note that the system recognizes if the user is a TMA or contractor user and will display the appropriate options. For example, a contractor is able to print only their own data (i.e., sets assigned to this contractor or region) and not data of other contractors. TMA users are able to generate reports containing data from all contractors.

The report parameter screen presents available options for data selection criteria based on the user type and the type of report format selected. For example, some report formats permit users to include institutional data, non-institutional data, or both in a report. Other formats are exclusively dedicated to either institutional or non-institutional data. Some report formats permit users to include data based on a range of dates while others do not.

The parameter screen detects the user type and the report format selected and displays only those data selection criteria options available for the user and the selected format.

The date range options on the report parameter screen allow a user to specify a selection of sets or claims based on a range of different dates such as:

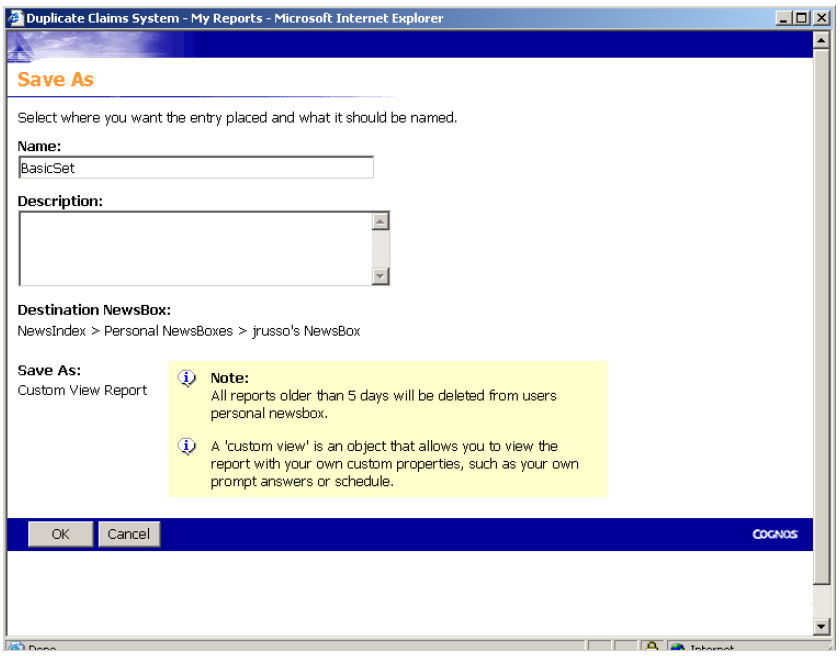
- Processed To Completion (PTC) Date - the date when the claim was PTC.
- Initial Load Date - the date when the set was initially loaded into the DCS.
- Current Load Date - the date when the set was loaded into the Duplicate Claims database or when a claim was appended to the set or when set ownership was changed as a result of a mass change or a change in the **Owner FI** field.

- Last Update Date - the date when the set was last updated by a user or by the system.

NOTE: *That regardless of the parameters the user selects, the reports will not include any data from provisional sets.*

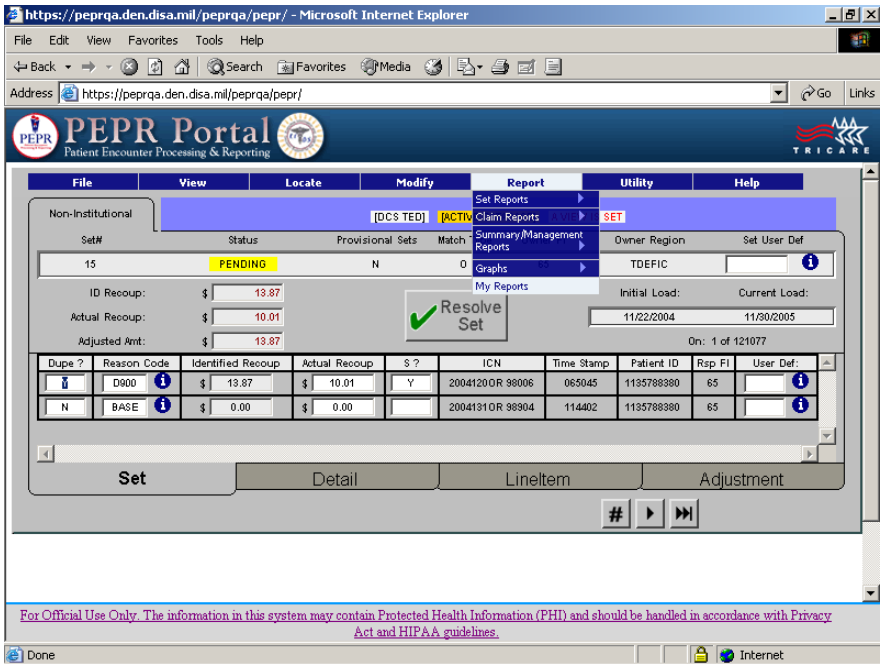
After a user selects a report format and data parameters and *selects the **SUBMIT** button,* the system *displays the SAVE AS SCREEN (Figure 10-8-3). At this time the user can enter a name for the report and may also add a description. This screen allows the user to continue and produce the requested report by selecting the **OK** button or cancel the request and return to the set by selecting the **CANCEL** button.*

FIGURE 10-8-3 SAVE AS SCREEN



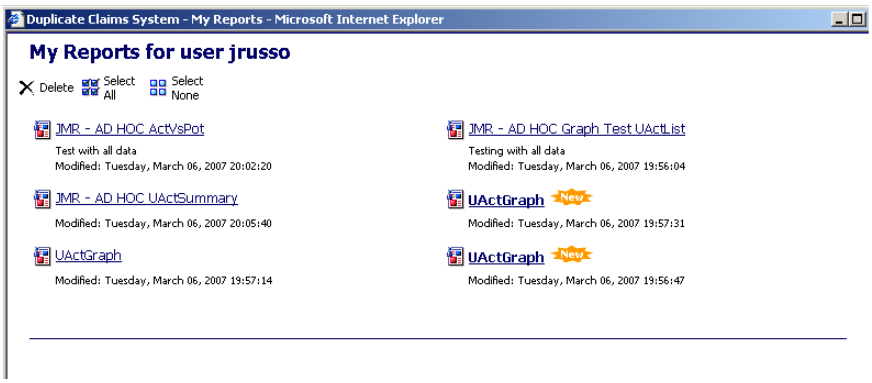
*If the user selects the **OK** button, the system brings the user to the **MY REPORTS** screen (Figure 10-8-4) that lists all the reports that have been run or requested. The reports that have not been reviewed, will display the caption "New". After five days, the reports on this menu will be deleted automatically. To review and/or print a report, select the report name.*

FIGURE 10-8-4 MY REPORTS SCREEN



*An optional way of getting previously submitted or completed reports is to select the **Reports** function and then select the **MY REPORTS** option from the pull-down menu (Figure 10-8-4). The following screen (Figure 10-8-5) will be displayed.*

FIGURE 10-8-5 REPORTS LISTING



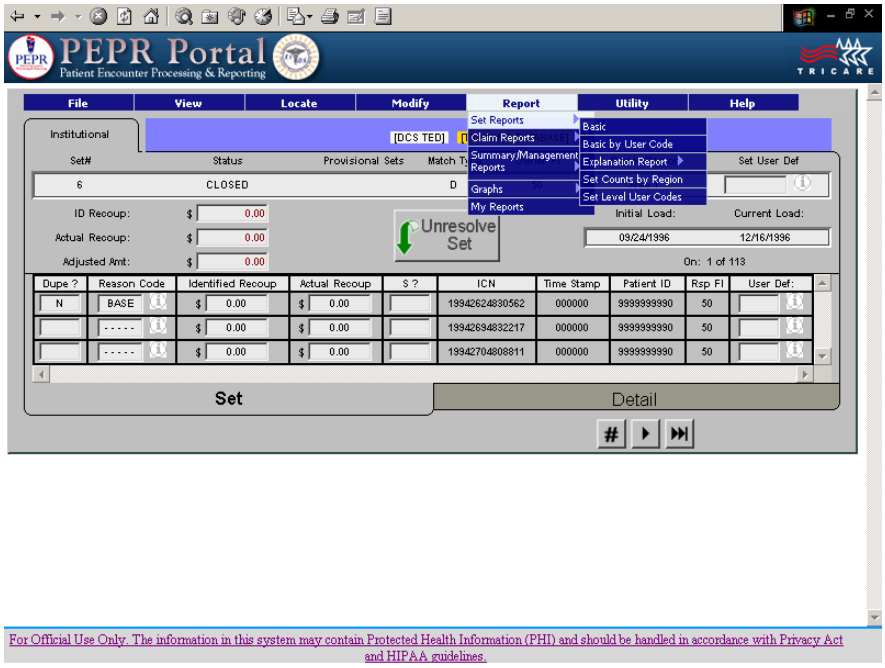
2.0. DESCRIPTION OF REPORTS

Addendum E contains a description and a sample of all available reports. The system groups reports into four categories, which are described briefly below. The first two categories of reports are based on set characteristics and claim characteristics. The other two categories of reports provide a range of summary and management analyses as well as graphical presentations of data. Each of the four categories of reports are further defined by menus to specify report formats and screens on which report parameters can be specified.

2.1. Set Reports

Set reports contain set information based on selection criteria established by the user. In other words, if a set has met the selection criteria for a report, all claims in the set will be included. Set reports are defined through menu(s) of set report formats and report parameter screens. A sample of set report menus are shown in *Figure 10-8-6*.

FIGURE 10-8-6 SET REPORT MENU



2.2. Claim Reports

As the name suggests, claim reports contain listings of individual claims that meet specific criteria based on the report format selected and the filters applied by the user on the report parameter screen(s). Sample claim report menus are shown in *Figure 10-8-7*. Examples of claim reports are:

2.2.1. All institutional claims in sets assigned to a particular region grouped by set status.

2.2.2. All claims in multi-contractor sets for a particular region by set status and within a specified initial load date time frame.

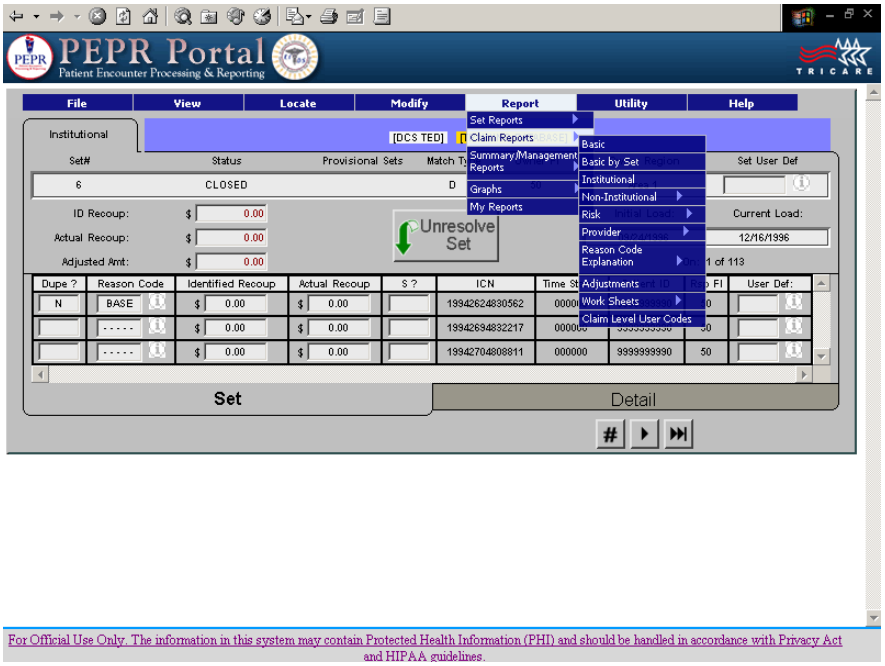
2.2.3. All claims identified as an actual duplicate in a set with *Pending* status and with a last update date between a specified date range.

2.2.4. All non-duplicates for a specified region which are not BASE claims.

2.2.5. Special report formats for Claim Reports have been developed for use by a contractor during the various stages of the claim set life cycle. For example, there is a report

format that lists the claims identified as actual duplicates for which recoupment should be initiated. This report could be generated by a person researching potential duplicates and sent to the recoupment unit daily. Another report format lists those claims for which recoupments have been received. This report could be generated by a contractor finance unit and sent to the adjustment unit when adjustments/cancellation TEDs need to be submitted.

FIGURE 10-8-7 CLAIM REPORT MENU



2.3. Summary/Management Reports

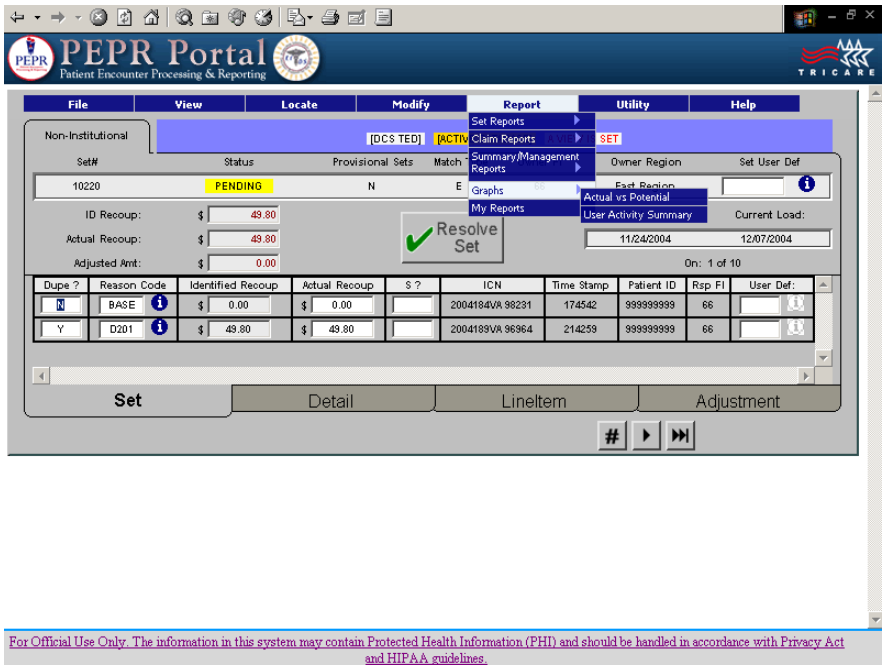
Summary/Management Reports display claims and other system data in formats which facilitate analyses and management functions. Sample summary/management report menus are shown in *Figure 10-8-8*. Examples of Summary/Management reports are:

- Set aging reports.
- Claim aging reports.
- Performance reports.

FIGURE 10-8-8 SUMMARY/MANAGEMENT REPORT MENU

2.4. Graphs

FIGURE 10-8-9 GRAPHS MENU



The Graphs category of reports displays data in graphical presentations that are useful in management analysis. For example, there is a graph that displays data regarding

user activity. Another provides a graphical representation of actual versus potential duplicates. *Sample of the Graphs menu are shown in Figure 10-8-9.*

The categories of report formats, in concert with report parameter screen options, provide users with flexible reporting tools to generate a wide range of reports. If a desired report cannot be devised through the use of the available report formats and the parameter screen options, users have the ability to download their data to their local hard drives, perform their own queries, and generate customized reports using their own database management spreadsheet, or report generation software.

See *Addendum E* for available report formats.

3.0. USING THE UTILITY FUNCTION TO DOWNLOAD DATA FOR ADDITIONAL ANALYSIS

Users have the capability to download duplicate claims data to their local system for additional analyses and reporting. This feature permits downloading of a contractor's data to a local PC, where it can be accessed from a PC-based database management program (e.g., Paradox®, *Microsoft* Access®, dBase®, etc.) or a spreadsheet program or query/report generator. This feature permits the user to perform analyses and develop reports not available in the *DCS*. Depending on the volume of data associated with a particular contractor, the process of downloading data could take some time.

3.1. How To Download Data

To initiate a download, a user should first *set a view for the data to be downloaded then* select **U**tility from the menu bar at the top of the screen*, select DOWNLOAD FROM UTILITY SCREEN then a* pop-up menu appears explaining that the user can download the current "**V**iew" to local ASCII fixed length tables and save them to a directory of the user's choice by clicking the 'Yes' box. A 'No' box is also provided to cancel or change the request. If the user clicks 'Yes', a matrix is displayed showing the names and brief descriptions of tables that can be downloaded. The user should follow the directions provided and click on the table(s) to be downloaded. A checkmark (✔) will appear to indicate the table(s) that have been selected. The user also can change the default directory to specify another directory to which the download should be saved. Tables available for downloading are:

dcset	set level data
dcclm	claim level data
dcutlztn	line item data
dcutladj	adjustment data
dcsetcmt	set level comments
dccmnt	claim level comments
dcsetlog	set log
dcsetusr	set level user defined codes
dcclmusr	claim level user defined codes
dccount	set counts
dccontract	region table
dcfi	FI/Contractor table

dcreas	reason codes
dcenroll	*enrollment codes*

While the download is being processed, the system will display the message: "**Accessing Database.... Working.... Please Wait**". This process can take several minutes or hours, depending on the number of claims/sets to be downloaded. The download will create ASCII *fixed-length* text files (files with extension of "txt").

If a user uses the ASCII fixed-length files to generate reports, tables have to be defined in the database management software selected (dBase®, *Microsoft* Access®, etc.) and the ASCII files imported. *Addendum F,* contains all of the information necessary to create the files, including the key or index fields.

It should be noted that downloaded files cannot be uploaded to TMA systems. This is a security feature to prevent corruption of the Duplicate Claims database.

*From the **Utility** menu, the **Download** pull-down menu allows the user to request a new download or preview previously requested downloads (Figure 10-8-10).*

FIGURE 10-8-10 DOWNLOAD MENU

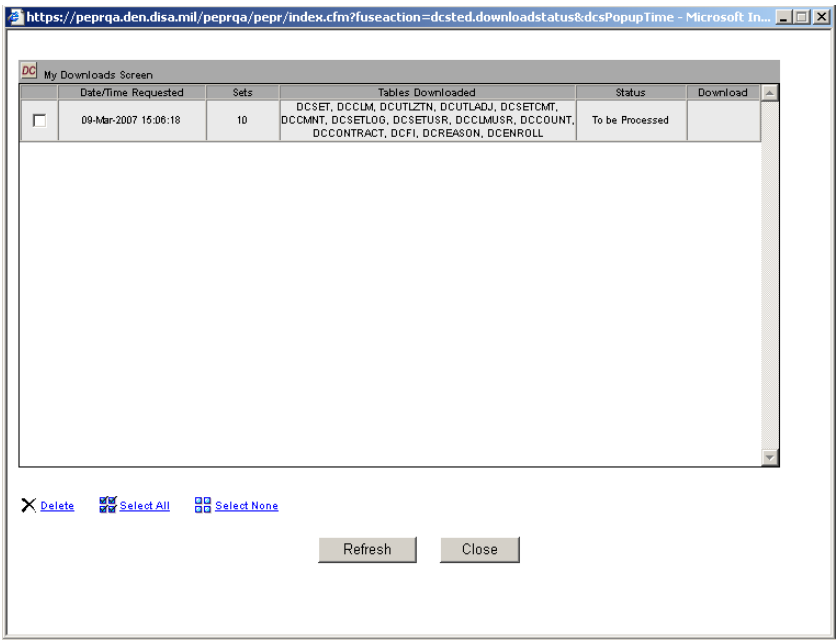
3.2. Specifying Data To Be Downloaded

Data to be downloaded may be specified in two ways. First, users should set a view through the View function of the menu bar to select specific claim types, set statuses, FIs/regions, match criteria, load dates, PTC dates, owner types, etc. Then, through the Download feature of the Utility function users may specify the data tables to include in the download.

FIGURE 10-8-11 NEW REQUEST PROMPT

*To view download requests, select the MY DOWNLOAD from the **U**tility function. A screen showing the current pending and completed downloads will be displayed (Figure 10-8-12).*

FIGURE 10-8-12 MY DOWNLOADS



SYSTEM IMPLEMENTATION AND OPERATIONAL REQUIREMENTS

This section describes implementation requirements for the Duplicate Claims System *(DCS)*. It also defines policies and procedures for the operation of the system.

1.0. SYSTEM COMPONENTS

The *DCS* is a *web-based* application operating as a customized graphical user interface. The application runs under Microsoft® *Internet Explorer (MSIE), Version 5.5, 6.0, or 7.0 or as directed by the Government*, and interfaces with tables that store the Duplicate Claims database. Access to the *DCS* will be through *MSIE, Version 5.5, 6.0, or 7.0 or as directed by the Government*.

2.0. HARDWARE AND SOFTWARE REQUIREMENTS

The requirements below are for user *personal computers (*PCs*)*, user printers, communications, software, and security.

2.1. *Hardware* Requirements

There are no specific minimum hardware requirements. As a general rule of thumb, the requirements, as specified by the vendor for the specific version of MSIE should be followed. In addition, using a high bandwidth connection is suggested.

2.2. Printer Requirements

Existing printers may be used for the *DCS*.

2.3. Communications Requirements

Contractors are required to connect the*ir hardware to* the *DCS through the Patient Encounter Processing and Reporting (PEPR) Portal using MSIE, Version 5.5, 6.0, or 7.0 or as directed by* the Government. The contractor must ensure that the connection has been tested.

2.4. Software Requirements

The software listed below must be installed and operational on each PC.

2.4.1. Operating System Software

No specific requirement.

2.4.2. Communications Software

MSIE, Version 5.5, 6.0, or 7.0 or as directed by the Government.

2.4.3. Application Software

No specific requirement.

2.4.4. Optional Software

Contractors may, at their own option and expense, procure and utilize full version database management software packages such as Microsoft Access®, dBase®, Paradox For Windows®, etc., on the *DCS* PCs for the purpose of generating customized queries and reports utilizing optionally downloaded *ASCII fixed length files* that can be created by the *DCS*. Downloaded *ASCII fixed length files* may also be imported into Microsoft Excel®.

2.5. Security Requirements

Security procedures require that all contractors identify a Security Manager to be responsible for overseeing the *DCS* registration process. *DCS* registration involves the submission of *one* security document, *for each user,* which may be copied from this chapter or obtained from *through* the *Help Desk*. The *one* document *is*: *TRICARE DCS Account Activation Request* Form (Figure 10-9-1). Each *DCS* user must complete and sign the required form*(*s*)*.

In order to access the *DCS*, users must obtain a User ID and an initial password from *the TRICARE Management Activity (*TMA*)*. User IDs and initial passwords will be issued following receipt *and processing* of properly completed registration and security forms. Contractor users should provide the required information, and submit the completed form to their *DCS* Security Manager for signature and transmittal to TMA.

DCS data must be encrypted. Encryption specifications will be provided by TMA. See the TRICARE Systems Manual *(TSM)*, Chapter 1 for additional security and communications requirements.

2.6. DCS Logon And Password Procedures

2.6.1. Change Password

The following are the steps for users to logon to the DCS and change their password.

2.6.1.1. *Passwords can be changed upon entering the PEPR Portal when the **Profile** link appears on the PEPR Toolbar (in the upper right side of the screen). Click on the **Profile** link.*

2.6.1.2. *Select **Change Password** on the USER PROFILE SCREEN and follow the prompts. The **Change Password** form dialog box will appear.*

2.6.1.3. *The dialog box will ask the user to enter the old password, the new password, and retype the new password in the **Verify** box. Enter all three and click the **Submit** button. If the User ID is*

*correct and the old, new, and verify passwords are correct, the message "**Password Successfully Updated**" will come back. See paragraph 2.6.4.*

2.6.1.4. *At the time of the logon, i*f the *u*ser's password is due to expire in 15 *or less* calendar days, a message box will appear asking the user if they want to change their password now. If the user selects 'No', they will be *sent* to the DCS. If the user selects 'Yes', they will be *sent* to the *USER PROFILE SCREEN*. The *USER PROFILE SCREEN* will *have* a ***Change Password** option*.

2.6.1.5. The user should click on the ***Change Password** option* and the ***Change Password** form d*ialog *b*ox will appear.

2.6.1.6. The user should type in their old password and enter a new password twice. *See paragraph 2.6.4.*

2.6.1.7. After the user completes this process, they will be returned to the *"Welcome to the PEPR Portal" s*creen where they may click on the ***DCS** link that will send them to the "Welcome to the DCS System" screen*.

2.6.1.8. *The user can click on the "Duplicate Claim System (DCS-TED)". This will bring the user to the "TRICARE Duplicate Claims System" screen where they can click on the **ACTIVE DATABASE**, **HISTORY DATABASE**, **TRAINING DATABASE**, or **EXIT** buttons.*

2.6.2. Password Expiration Notifications

2.6.2.1. *Passwords must be changed at least every 89 days or as otherwise specified by the government. Beginning 15 days before the password will expire, the user will be told the number of days before the password will expire, and be asked if they want to change the password now. If the user does not change the password by the last day, the User ID will be locked out, and the user must call the Military Health System (MHS) Help Desk to have the User ID re-installed.*

2.6.2.2. If a user's password has expired, the *system* will display a message box informing the user, "**Your password has expired.**" Please call the ***MHS*** **Help Desk** at **1-*800-600-9332***, *then follow the prompts to* the DCS. *This will take the user to the San Antonio Help Desk.*

2.6.2.3. Users who have forgotten their passwords must call the ***MHS*** **Help Desk** at **1-*800-600-9332***, *then follow the prompts to the DCS. This will take the user to the San Antonio Help Desk*.

2.6.3. Password Process For New Users

2.6.3.1. Upon the receipt and processing of the required registration and security forms (see paragraph 2.7.), a TMA representative will notify the Security Manager or the user's supervisor of the new user's User ID and temporary password.

2.6.3.2. *Upon login to the PEPR Portal, t*he new user should now click on the ***Profile** link on the PEPR Portal Toolbar* which will bring up the *ACCESS SCREEN*. The new user should then click on the ***Change Password** option*. The DCS will then display the ***Change Password*** dialog box. The new user should then enter their temporary password *(old password)* and enter their new password twice *(new, verify)*.

2.6.3.3. Once the new password is accepted the new user will be taken to the *DCS ACCESS SCREEN* where they may click on the **ACTIVE DATABASE** or **HISTORY DATABASE** buttons to enter the DCS.

2.6.4. Password Specifications

2.6.4.1. Passwords must be at least *nine* characters long *and not greater than 12*.

2.6.4.2. Passwords must contain *all four character types with at least two of each of the following:* numbers, uppercase letters, lowercase letters, and special characters: **! @ # $ % ^ * ( ) _**.

2.6.4.3. Passwords must **not** contain any of the following special characters: **\ - ; : " ' / ~**.

2.6.4.4. A user may not re-use one of their last *12* passwords.

2.6.4.5. Passwords must be changed at least every 89 days *or as otherwise specified by the government*. *Beginning 15 days before the password will expire, the user will be told the number of days before the password will expire, and be asked if they want to change the password now. If the user does not change the password by the last day, the User ID will be locked out, and the user must call the* ***MHS Help Desk*** *to have the User ID re-installed.*

2.6.4.6. A user cannot change their password more than once in any 24 hour period.

2.6.4.7. Temporary passwords provided by TMA to new users, users whose passwords have expired, or to users who have forgotten their passwords must be changed immediately.

2.6.4.8. If a user attempts to log-on to the DCS with an incorrect password three consecutive times, their User ID will be locked and disabled and the user must call the ***MHS*** **Help Desk** at **1-*800-600-9332*** *(follow the prompts to the DCS, this will take the user to the San Antonio Help Desk)* to have their User ID unlocked.

2.7. Registration And Security Form - TRICARE *DCS Account Activation Request* Form (see Figure 10-9-1)

Each individual user must complete and sign the top portion of the TRICARE *DCS Account Activation Request* Form. The following are the required data elements to be provided by each user:

1. *System Access: Select from Web or Client/Server (C/S) Version*
   - *Select from Web or C/S Version*

2. *Employment Category*

3. *Applicant/Requestor Information*
   - *Rank/GS Level/Title:*
   - Name: (Last, First, MI)
   - *Complete Office Mailing Address*
   - *Sponsoring Organization: (Not Project Name)*

- *If Contractor, Employer Name* (Contractor Name, e.g., PGBA, Humana, TriWest, WPS, Health Net, etc.)
- *Commercial* Telephone *Number*: (include area code)
- *DSN*:
- User's e-mail address:
- *IP Address of Workstation (C/S only):*
- *Network Translated IP Address (C/S only):*
- *Account Validation PIN: (four digit numeric PIN to use when validating identity)*

4. Password Action/Access Authorization Requested
- *Check action Requested: (Select New, Change, Delete, or Other with explanation)*
- *Enter User ID if the user already has one for the DCS*
- *Requested Access: Read Only; Read/Write (see 4.A.)*
- *Region Contractor Numbers: (62, 63, 64, 65, FO)*

4.A. Special Permissions Data for Read/Write Users (To be completed by requestor's supervisor)
- *Permission to create User Defined Codes? (Requires Prime Contractor approval)*
- *Permission to unarchive sets? (Requires Prime Contractor approval)*

5.A. Executive Information and Decision Support (EIDS) Security Awareness Training and Test (Not required for Managed Care Support Contractors (MCSCs))
- *Must have completed the EIDS Security Awareness Training and Test*
- *Must have signed and faxed the EIDS Security Awareness Certificate to EIDS*

5.B. Proof of Security Awareness Training (Required for MCSCs)
- *Must have a letter on file with EIDS verifying internal annual security awareness training requirements.*

6. Data Use Agreement (DUA) for Contractor (Not applicable for MCSCs)
MHS Contractor and/or non-MHS Employee must provide the following:
- *Employer Name:*
- *Project Description requiring this access:*
- *The DUA number for this project:*
- *Project period of performance:*

7. User Security Clearance Level (Mark the appropriate level)

8. TRICARE DCS Account Applicant Signature (All Applicants/Users must read and sign)
- User's Signature

Once the user has completed this portion of the form, it should be forwarded to the user's supervisor who can provide the permissions data in the *4.A.* block of the form. Supervisors should note that only certain users should be granted these permissions since execution of these functions will affect the data in the DCS and may increase the volume of sets required to be worked. Only experienced users should be granted these permissions.

Prime contractors should be careful when granting these permissions. The following information must be provided:

- Permission to create User Defined Codes? (A "Yes" requires written or verbal approval from the Prime contractor. The supervisor should obtain the Prime contractor's approval. TMA will verify a "Yes" answer with the Prime contractor.)
- Permission to unarchive sets? (A "Yes" requires written or verbal approval from the Prime contractor. The supervisor should obtain the Prime contractor's approval. TMA will verify a "Yes" answer with the Prime contractor.)
- Supervisor's signature.
- Supervisor's telephone number.

Once the supervisor has completed this portion of the form, it should be forwarded to an individual (preferably an Information Technology Representative) who can provide the Site Hardware and Communications Data in the third block of the form. The following information must be provided:

- *Connection established to PEPR Portal*? (The answer to this question must be "Yes" before a User ID will be issued. "Yes" verifies that the PC can establish communication with the TMA server. See paragraph 3.0., for server address.
- Location of computer: (building number, unit name, etc.)

Once this portion has been completed the form should be forwarded to the Contractor Security Manager for review and signature.

3.0. CONNECTIVITY

Connectivity will be through the internet to the PEPR Portal via MSIE, Version 5.5, 6.0, or 7.0 or as directed by the Government.

4.0. SYSTEM SUPPORT

4.1. For *DCS* support, contractors should call the ***MHS*** **Help Desk** at **1-*800-600-9332***, *then follow the prompts to the DCS*. *This will take the user to the San Antonio Help Desk.*

4.2. System upgrades will occur automatically when users sign on to the system.

5.0. SYSTEM INSTALLATION AND TRAINING

5.1. Contractor Installation Responsibilities

Contractors are responsible for installing the *MSIE, Version 5.5, 6.0, or 7.0 or as directed by the Government, and Adobe Reader, on their hardware*, and *establishing* connectivity *to the PEPR Portal*. In addition to the communications software required to establish connectivity to the

web-based DCS, contractors are responsible for installing their preferred operating system on the*ir hardware*.

5.2. Training

TMA will provide training to prospective users of the *DCS*. *The training may be on-line or in person at a central location. TMA will coordinate with each contractor once the approach is defined.*

6.0. CONTRACTOR POINTS OF CONTACT *(POC)*

To resolve multi-contractor duplicate claim sets, contractors are required to communicate and coordinate with each other (see *Section 6*). For each regional contract for which a contractor is responsible, the contractor is required to identify at least one individual to serve as the *DCS POC*. Contractor POCs must be individuals who are, or will be, trained in the use of the *DCS*, and are able to perform the required research and determine whether a particular claim is within their processing jurisdiction. For each regional contract for which they are responsible, contractors shall provide the name(s), title(s), business address(es), and business telephone number(s) of their *POCs* to the Contracting Officer *(CO)*, with courtesy copies to the Contracting Officer Representatives (CORs) and to the TMA DCS Program Representative. The POCs shall be provided to the *CO* no later than *(NLT)* two weeks prior to implementation of the *DCS*.

Prior to system implementation, TMA will provide each contractor with the list of all *DCS* POCs. Whenever a new contract is awarded, TMA will notify all contractors of the new *c*ontractor's POC. Once the initial listing is provided to the contractors, it is the responsibility of each contractor to maintain the listing and keep TMA and the other contractors informed of any changes.

7.0. OPERATING PROCEDURES

For each regional contract for which a contractor is responsible, or for the TRICARE Dual *E*ligible FI Contract (TDEFIC), the contractor shall develop internal operating procedures for the *DCS*. These internal operating procedures shall designate the responsible areas for the various duplicate claims resolution functions and establish time lines. For example, one contractor may decide that the adjustment unit shall be responsible for scanning the *DCS* on a weekly basis for the appearance of adjustments submitted and for closing sets. Another contractor may decide that the unit responsible for researching potential duplicate claims should also be responsible for scanning for adjustments and closing the sets on a daily basis.

Contractor contract requirements for overpayment recovery, refunds and offsets, adjustments, etc., including timeliness requirements, apply to the operation of the *DCS*. As a result, operating procedures must be developed which are consistent with all applicable contract requirements. Procedures must be established to ensure that recoupments are initiated in a timely manner following the research determination that a duplicate payment had been made. In other words, procedures must specify that after a decision has been made by the person responsible for determining that a duplicate payment was made, recoupment

must be initiated in a timely manner and must be consistent with all overpayment recovery timeliness standards.

Contractors shall develop these procedures within 60 days of the date of system implementation and have them available for TMA review.

8.0. CONTRACTOR PERFORMANCE REQUIREMENTS

8.1. Contractors shall use the TRICARE *DCS* to resolve TMA identified potential duplicate claims payments.

8.2. Contractors shall move *Open* status potential duplicate claim sets to *Pending*, *Validate*, or *Closed* status on a first-in/first-out basis. To this end, contractor performance will be measured against the percentage of claim sets in *Open* status at the end of a month with Current Load Dates over 30 days old. No more than 10% of the potential duplicate claim sets remaining in *Open* status at the end of a month shall have Current Load Dates over 30 days old. Contractor compliance with this standard shall be determined from the Performance Standard Report generated by the *DCS* (see *Addendum E*, Summary Management Report titled "Performance Standards", for a description and example of the Performance Standard Report). The 10% standard becomes effective on the first day of the seventh month following the start of Services or following system installation whichever is later.

8.3. Contractors shall not be responsible for meeting the performance standard during any month in which availability of the *DCS* is prevented for two working days due to failure of any system component for which the Government is responsible. The Government is responsible for: TMA servers on which the *DCS* data resides; Government-supplied communications lines, if any; Government-supplied routers, if any; Government-supplied *Channel Sending Unit (*CSU*)/Data Sending Unit (*DSU*)* equipment that connect the routers to the communication lines, if any; and the *DCS* application software.

8.4. Contractors are responsible for their own PCs, printers, PC operating system software, and in-house communications software and equipment, including in-house *Wide Area Network (*WAN*)/Local Area Network (*LAN*)* equipment, circuits, and routers. Contractors are responsible for any *c*ontractor-supplied communication lines, *c*ontractor-supplied routers, and *c*ontractor-supplied CSU/DSU equipment that connect the routers to the communication lines. Contractors are responsible for *c*ontractor-supplied internal and external networks, network connections to the routers, firewalls, and all software (including operating system, application, and network software) other than the *DCS* application-related software. Contractors are required to install and maintain *hardware with MSIE, Version 5.5, 6.0, or 7.0 or as directed by the Government, and Adobe Reader*. Contractors are responsible for maintaining their own networks, including hardware and software (other than the *DCS* software). TMA will fully support the *DCS* application software.

8.5. All overpayment recovery, refund, offset collection and adjustment requirements, including timeliness standards, are applicable to the operation of the *DCS*.

9.0. TRANSITIONS

The date when an incoming contractor will assume full responsibility for resolving all existing potential duplicate claim sets from the outgoing contractor (including completing existing recoupments), and for all new potential duplicate claim sets, shall be determined during transition meetings and be established in the transition plan/schedule. The criteria for the types of claims for which the outgoing contractor will retain responsibility (e.g., financially underwritten/non-financially underwritten claims), and the types of claims to be transferred to the incoming contractor, will also be defined in the transition plan/schedule.

FIGURE 10-9-1 TRICARE DCS ACCOUNT ACTIVATION REQUEST FORM

TRICARE Duplicate Claims System Account Activation Request Form

See Pages 5-6 for Form Instructions and Guidance

Upon Completion of this Form Including Block 9 & Attachment A, Fax to 303.676.3979

1. System Access (Please check the system for which you have mission/contract related access requirement)	
	DCS - Web Version DCS
	Client/Server (C/S) Version

2. Employment Category (Please check the category that applies)	
	Government Employee, Uniformed Service Member, Military, or Civil Service working within/for DoD MHS
	Contractor working within the DoD Military Health System
	Government Employee, Uniformed Service Member, Military, or Civil Service working for other agency or directorate not a part of the DoD Military Health System
	Contractor working for Government Agency, not a part of the DoD Military Health System
	Other (Please describe) _____

3. Applicant/Requestor Information	
Rank/GS Level/Title:	
Name (Last, First, MI):	
Complete Office Mailing Address:	
Sponsoring Organization Name: (Not Project Name)	
If Contractor, Employer Name	
Commercial Telephone Number:	
DSN:	
Email:	
IP Address of Workstation (Client Srvr only)**:**	
Network Translated IP Address (Client Srvr)**:**	
Account Validation PIN: Enter a 4 digit numeric PIN that you will use to validate your identity for account administration purposes. **This must be the same number as entered when registering in the EIDS WebPortal.**	

4. Password Action/Access Authorization Requested

Check action requested: ❑ NEW ❑ CHANGE ❑ DELETE ❑ OTHER _____

If you have a User ID, please enter it here: _____ (If your account has expired, enter your last user ID)

Requested Access: ❑ **READ ONLY** ❑ **READ/WRITE (supervisor must complete 4.A., below)**

Requesting Access to following contractor region number(s)*: _____

* If access to multiple contractor regions is required, all region contractor numbers must be specified.

4.A. Special Permissions Data for READ/WRITE Users (To be completed by requester's supervisor)

Permission to create User Defined Codes? (Requires Prime Contractor approval): ❑ YES ❑ NO

Permission to unarchive sets? (Requires Prime Contractor approval): ❑ YES ❑ NO

Supervisor Signature: _____ **Phone#:** _____

Prime Contractor Signature: _____ **Phone#:** _____

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FIGURE 10-9-1 TRICARE DCS ACCOUNT ACTIVATION REQUEST FORM (CONTINUED)

5.A. EIDS Security Awareness Training and Test (Not required for MCSCs)

1. Have you successfully completed the EIDS Security Awareness Training and Test? ❑ YES ❑ NO
2. Have you signed and faxed the EIDS Security Awareness Certificate to EIDS? ❑ YES ❑ NO

5.B. Proof of Security Awareness Training (Required for MCSCs)

1. Is a letter on file with EIDS verifying internal annual security awareness training requirements? ❑ YES ❑ NO

6. Data Use Agreement (DUA) for Contractor (Not applicable for MCSCs)

If you are an MHS Contractor and/or non-MHS Employee, please provide the following information:

Employer Name:	
Project description requiring this access:	
What is the DUA # that exists for this project?	
Project period of performance:	

7. User Security Clearance Level (mark appropriate level):

	ADP II	Notes: 1. A minimum of ADP Level II is required. 2. The use of SECRET is authorized if the requestor's clearance has been active within 2 years of application date.
	ADP I	
	Other (specify) Type _____ Date _____	
	If SECRET, provide: Date of Birth: _____ Place of Birth: _____	

8. TRICARE DCS Account Applicant Signature (All Applicants/Users must read and sign)

By signing below, I am acknowledging that (1) all statements made on this form are true and correct; and (2) I am only authorized to use TRICARE DCS for my current position/duty and agree to relinquish my TRICARE DCS accounts to the EIDS Program Office upon departure from my current position/duty. I understand and accept that my use of the system may be monitored as part of managing the system, protecting against unauthorized access and verifying security problems. I further acknowledge that substantial civil and criminal penalties including fines up to $50,000 and one year imprisonment, and/or administrative sanctions may be levied against those who violate the provisions of the Privacy Act of 1974 and/or the Health Information Portability and Accountability Act (HIPAA) of 1996.

Signature _____ **Date** _____

ALL APPLICANTS MUST ALSO COMPLETE AND SIGN ATTACHMENT A (PAGE 4)

9. Commander, Supervisor, or Security Officer Certification of Citizenship

By signing below, I am certifying that _____ (applicant) is a U.S. Citizen and has a mission essential or contract-driven requirement to access DCS, and that the DUA referenced, if any, is applicable. I further acknowledge that substantial civil and criminal penalties including fines up to $50,000 and one year imprisonment, and/or administrative sanctions may be levied against those who violate the provisions of the Privacy Act of 1974 and/or the Health Information Portability and Accountability Act (HIPAA) of 1996. I shall notify the EIDS Program Office upon departure of this applicant from their current position/duty or when access is no longer required.

Commander/Supervisor/Security Officer Name	
Title or Position	
Organization, Office, Company	
Office Mailing Address:	
Email Address	
Commercial Telephone	
DSN	

Signature _____ **Date** _____

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FIGURE 10-9-1 TRICARE DCS ACCOUNT ACTIVATION REQUEST FORM (CONTINUED)

UPON COMPLETION OF BLOCK 9 AND ATTACHMENT A, FAX THIS FORM TO 303-676-3979.

10. Government Sponsor (usually TMA)	
Sponsoring Organization Name	TMA - Purchased Care Systems Branch
Commander / Supervisor / Sponsor Name (Last, First, MI)	
Title	
Office Mailing Address	16401 E Centretech Pkwy Aurora, CO 80011-9066
Email Address	
Commercial Telephone	
DSN	
Access Level Approved	❑ Read Only ❑ Read/Write ❑ R/W/Admin
Unarchive Sets?	❑ Yes ❑ No
Create User Defined Codes?	❑ Yes ❑ No
Contractor Region Numbers Granted	

Government Sponsor Signature _____ **Date** _____

DO NOT WRITE BELOW THIS BOX

11. EIDS Certification (For EIDS use only)	
❑ Form ❑ SAC ❑ WPValidPIN ❑ AppSigned ❑ CertSigned ❑ SponSigned EIDSAccess _____ ❑ NTK _____	
I certify that EIDS requirements have been validated. Specified access is recommended.	
EIDS PO Approving Authority Name	

Signature _____ **Date** _____

12. TMA Privacy Office Approval (For TMA use only)

I certify that the applicant has ❑ has not ❑ met the requirements for ADP/IT security levels of trust; and

Has an approved DUA on file with the TMA Privacy Office ❑ YES ❑ NO ❑ N/A (Government & Military); and

Is a U.S. Citizen ❑ or has provided proof of U.S. Citizenship as required. ❑

That the access level and justification is ❑ is not ❑ appropriate for their system use.

The Privacy Office approves ❑ does not approve ❑ the request for access to the MHS system.

HPA&E, TMA Privacy Office

Signature _____ Date _____

Email Address dua.mail@tma.osd.mil

13. User ID Creation (EIDS SysAdmin creates AIX ID, TMA-Aurora creates Portal ID and DCUSER entry)

PEPR Portal ID created (Web Only):	_____	Signature: _____	Date: _____
AIX ID Created (C/S Only):	_____	Signature: _____	Date: _____
DCUSER ID Created (All):	_____	Signature: _____	Date: _____

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FIGURE 10-9-1 TRICARE DCS ACCOUNT ACTIVATION REQUEST FORM (CONTINUED)

Attachment A

Justification for Access to Protected Health Information (PHI)

(Required for DCS access)

Generally speaking, only healthcare providers involved in the treatment of patients are allowed access to patient-identifying data regarding patients under their care. Such access could also extend to healthcare managers and administrative support personnel with specific, defined roles regarding paying or receiving reimbursement on medical claims and essential activities in support of health care operations. The use or disclosure of protected health information outside these parameters and without the patient's consent may violate the Privacy Act of 1974 and/or the Health Insurance Portability and Accountability Act of 1996 (HIPAA). A more detailed description regarding the required protection of individually identifiable data is available at **http://www.usdoj.gov/04foia/privstat.htm** and **http://www.tricare.osd.mil/hipaa/**.

Please identify your requirements for access to patient identifiable data.

_____

_____

_____

Privacy Act

Some data are protected under the provisions of the Privacy Act of 1974. The data contains patient and provider identity information and thus requires safeguards from unauthorized access and use. I agree to comply with the Privacy Act of 1974 and to be responsible for the use of this data to properly safeguard patient and provider identifying data in accordance with the 30 Oct 2001 OASD(HA) memorandum signed by Major General Randolph, Deputy Executive Director TMA, subject "*Supplemental Guidance for the Management and Control of Patient Sensitive/Medical Record Information in the Military Health System.*" In addition, I acknowledge that I may be subject to civil suit under the Privacy Act or 1974 for damages which occur as a result of willful or intentional actions which violate an individual's rights under the Privacy Act of 1974.

Protected Health Information (PHI)

I accept responsibility for the PHI data in DCS that is in my possession and will ensure that all reasonable efforts are made in order to protect the data from unauthorized access and misuse.

HIPAA

I acknowledge that under HIPAA (P.L. 104-191), Congress has established criminal penalties for knowingly violating patient privacy. Criminal penalties are up to $50,000 and one year in prison for obtaining or disclosing protected health information; up to $100,000 and up to five years in prison for obtaining protected health information under "false pretenses"; and up to $250,000 and up to ten years in prison for obtaining or disclosing protected health information with the intent to sell, transfer or use it for commercial advantage, personal gain or malicious harm.

User Signature _____ **Date** _____

Printed Name _____

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FIGURE 10-9-1 TRICARE DCS ACCOUNT ACTIVATION REQUEST FORM (CONTINUED)

Instructions and Guidance for
TRICARE Duplicate Claims System Account Activation Request Form

1. **System Access.** Select which DCS system you wish to access.

Overview of the System

DCS	The TRICARE Duplicate Claims System (Duplicate Claims System or 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) or TRICARE Encounter Data (TED) database. The system also generates operational and management reports.

2. **Employment Category.** Check category that applies.

3. **Applicant/Requestor Information.** Please fill in all applicable fields. "IP Address of Workstation" and "Network Translated IP Address" are only required for accounts being created for the Client/Server version of DCS. You must select a 4-digit Account Validation PIN. It may be any 4-digit number that you will remember if needed to verify your identity for account administration purposes (i.e. password reset). For instance, you may use the last 4-digits of your social security number or month and day of birth, etc. This number must be the same as the Account Validation PIN you have entered at the EIDS WebPortal: http://eids.ha.osd.mil and as provided for other EIDS systems, as applicable.

4. **Password Action/Access Authorization Requested.** Check to indicate whether this is a request for a new DCS user account or an account or password change, account deletion or reactivation. If you have a user ID, please provide it. If your account has expired, please provide your last user ID if known.

4.A. **Special Permissions Data for Read/Write Users.** Select the various special permissions required for your mission or contract related work. These special permissions must be approved by your supervisor and prime contractor.

5.A. **EIDS Security Awareness Training and Test (all applicants except MCSC).** DoD Directive 8500.2, "Information Assurance (IA) Implementation" requires that information system users complete Security Awareness Training on an annual basis. In accordance with this directive, the EIDS Program Office must have a copy of your Security Awareness Certificate on file.
If you have not completed online Security Awareness training in the past year, you will need to take the training, complete the quiz, download the form, sign it and send it via fax to EIDS Access at **866-551-1249**. The Security Awareness Certification can be accessed on the MHS Help Desk area of the EIDS Web site (**http://eids.ha.osd.mil**). See **How to Access the Security Awareness Training Manual and Test** on page 6 for step by step instructions on how to access the EIDS Web site and take the Security Awareness Test. You may also contact the MHS Help Desk by phone at 800-600-9332 for assistance.

5.B. **Proof of Security Awareness Training (MCSC personnel only).** The EIDS Security Awareness Training Certification is not required for MCSC personnel. A letter of proof of security awareness training must be on file with EIDS verifying internal annual security awareness training requirements were met.

6. **Data Use Agreement (DUA) Number (not applicable for MCSC personnel).** Non-MHS personnel (generally other DoD employees) and/or contractors working for the MHS/DoD requiring access to DCS data are required to have a current Data Use Agreement on file with the TRICARE Management Activity (TMA) Privacy Office. For information pertaining to Data Use Agreements, please refer to the TMA Privacy Office website at **http://www.tricare.osd.mil/tmaprivacy/**.

7. **Security Clearance Level.** All users of DCS must have a minimum security clearance of ADP Level II. Users should contact their organization's Security Officer or Personnel Office for assistance. For further assistance or direction on applying for an ADP II clearance, send an email to the TMA Privacy Office at **dua.mail@tma.osd.mil**.

FIGURE 10-9-1 TRICARE DCS ACCOUNT ACTIVATION REQUEST FORM (CONTINUED)

8. **DCS Account Applicant Signature.** All applicants must sign this form to verify the truth and accuracy of the information provided and understanding of the responsibility undertaken if requested system access is granted.
9. **Commander, Supervisor or Security Officer Certification of Citizenship.** The requestor's commander, supervisor, or security officer (the requestor's employer) must certify that the requestor is a U.S. Citizen and has a mission or contract related requirement to access the DCS. All fields must be completed. Signature is required.

Once Block 9 is complete, fax form to TMA - Purchased Care Systems Branch: 303-676-3937. Include Attachment A in your submission for access to PHI if required.

10. **Government Sponsor.** All fields must be completed. The Government Sponsor's signature is required.

Once Block 10 is complete, fax form to EIDS Access: 866-551-1249. Include Attachment A in your submission, if required.

11. **EIDS Certification.** For EIDS use only.

12. **TMA Privacy Office Approval.** For TMA Privacy Office use only.

13. **User ID Creation.** For TMA use only.

Attachment A. Justification for Access to Patient Identifiable Data.

All users require justification for access to the protected health information contained in DCS.
User justification and signature is required.

How to Access the Security Awareness Training Manual and Test

1. Log onto the EIDS Web portal at **http://eids.ha.osd.mil**

Note: If you do not have an EIDS Web account, follow these steps:

A. At the EIDS Web site, select **Register** from the horizontal menu bar.
B. Complete the registration form and click **Register**.
C. Make note of your EIDS Web site account information.
D. Click **Login** from the EIDS Web site and log in using your new EIDS Web account.

2. Click **MHS Help Desk** from the horizontal menu bar.
3. Read the Security Awareness Training Manual, and then take the Security Awareness Training Test.
   (a) Click on **Take the Security Awareness Training Exam**, listed at the end of the Security Training Manual; or
   (b) Click on **Security Awareness Training: Take the Test** from the MHS Help Desk screen.
4. Upon successful completion of the test, you are presented with an EIDS Security Awareness Certificate. Scroll to the bottom of the Certificate and download using the indicated link.
5. Per the form's instructions: print, sign, and fax the form to the EIDS Program Office, ATTN: EIDS Access at 866-551-1249.

KEEP A COPY OF THIS FORM IN A SAFE PLACE FOR YOUR RECORDS AND FUTURE REFERENCE.

DUPLICATE CLAIMS SYSTEM DISPLAYED DATA FIELDS

TED DATA ELEMENTS	
FIELD NAME	**DESCRIPTION**
Sponsor ID	Sponsor Social Security Number or Other Sponsor Identifier
Sponsor ID Type Code	Sponsor ID Qualifier
DOB	Patient Date Of Birth
Patient ID	Patient Sponsor Social Security Number or Other Patient Identifier
Provider Tax ID	Provider Taxpayer Number
Provider Sub ID	Multiple Provider ID
Proc Code/Proced Code	Procedure Code
Diagnosis	Principle Treatment Diagnosis Code
DRG	Diagnosis Related Group Number
Inst Admit Date	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)	Institutional Amount Billed Total
Billed Amount (Line)	Non-Institutional Line Item Amount Billed Total
Allowed Amount (Total)	Institutional Amount Allowed
Allowed Amount (Line)	Non-Institutional Line Item Amount Allowed
Place Serv	Place Of Service
Type Serv	Type Of Service
PTC Date	Processed To Completion Date
ICN	Internal Control Number
Prov Gp NPI	Provider Group National Provider Identifier
Time Stamp	System time assigned when issuing an initial HCSR

TED DATA ELEMENTS (CONTINUED)	
FIELD NAME	**DESCRIPTION**
Proc FI	HCSR FI Contractor Number
Processing Contract	Contract Number
Batch Sequence #	Batch Sequence Number
Voucher Sequence #	Voucher Sequence Number
Cycle Number	TMA Processing Cycle (Year, Month, Cycle Number)
Name	Patient Name
Age	Patient Age
Enrolled	Enrollment Status
Patient Zip Code	Patient Zip Code
Provider Zip Code	Provider Zip Code
Provider Network Status Indicator	Provider Network or Non-Network Indicator
Provider Specialty	Provider Specialty Code
Type Institution	Type Of Institution Code
Disp	Discharge Disposition
Govt Pd Amount (Line)	*Line Item Paid By Government Contractor*
Govt Pd Amount (Total)	Amount Paid By Government Contractor
L	Claim Line Item Number
TED Line #	Non-Inst Adjustment Line Item Number; For Inst = 00
Adjust PTC Date	Adjustment Processed to Completion Date
Govt Pd Amount (Adjustment)	Claim Level Adjustment Paid Amount for Institutional Claim Line Item Level Adjustment Paid Amount for Non-Institutional Claim
SPC 1	First Special Processing Code
SPC 2	Second Special Processing Code
SPC 3	Third Special Processing Code
SPC 4	Fourth Special Processing Code
SRC	Special Rate Code
PRC	Pricing Rate Code
NPI	National Provider ID
Claim Form Type	Primary Claim Form Submitted

GENERATED DATA ELEMENTS	
FIELD NAME	**DESCRIPTION**
Set #	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.
Risk	Financially underwritten, non-financially underwritten indicator for claim. *Please note that for the purposes of this system:* *Financially underwritten = Risk* *Non-financially underwritten = Not at-risk.*
Mass Change Level	The latest MASS CHANGE cluster rule applied to the claim.
Patient Region	Patient health service region code.
Provider Region	Provider health service region code.
Owner FI	**Owner FI** represents, for the claim set, the 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 (**Resp FI**), in which case the **Owner FI** 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 **Owner FI** is originally assigned by the system to be the responsible FI/Contractor from the claim within the set having the latest processed-to-completion date.
Resp FI / Rsp FI	**Resp FI** or **Rsp FI** represents, for the claim, the contractor that is currently responsible for administering the claim. When the claim is initially extracted from TED, the **Resp FI** is identical to the **Proc FI** (Processing FI). However, contract awarding and transitions may require claim administration by a new contractor, in which case the system will assign a new **Resp FI** for the claim.

GENERATED DATA ELEMENTS (CONTINUED)	
FIELD NAME	**DESCRIPTION**
Owner Region	**Owner Region** is a narrative descriptor of the contract number and represents, for the claim set, the Owner FI/ Contractor region. Typically, all claims within a set will have the same **Responsible Contract**, in which case the **Owner Region** will be the same as the **Responsible Contract**. However, for multi-contractor claim sets where the contractors are not the same for all claims within the set, an **Owner Region** is assigned by the system to be the **Responsible Contract** from the claim within the set having the latest processed-to-completion date. The initial assignment is done in tandem with the assignment of **Owner FI**.
Responsible Contract	**Responsible Contract** represents, for the claim, the contract under which the claim is currently administered. When the claim is initially extracted from TED, the **Responsible Contract** is identical to the **Processing Contract**. However, contract awarding and transitions may require claim administration under a new contract, in which case the system will assign a new **Responsible Contract** for the claim.
Dupe?	**Dupe?** is an indicator to describe whether or not the claim or line item is a duplicate. During the extract processes **Dupe?** will be set to "N" (no) for the base claim within a set and will be set to blank for the remaining claims and line items.
Reason Code	**Reason Code** 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 **Dupe?** being set to "N") a reason code of BASE 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 explanation field for further elaboration.
TED Adjust?	**TED Adjust?** 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 **TED Adjustment** field is the sum (for the claim) of paid dollar amounts for those that apply. Display screens enable **TED Adjust?** to be checked for any institutional claim and any non-institutional line item.

GENERATED DATA ELEMENTS (CONTINUED)	
FIELD NAME	**DESCRIPTION**
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	**Identified Recoup** is a dollar amount that is entered by the user or by the system upon initial determination that a claim or a line item is a duplicate. It represents the amount of overpayment for the claim or line item that has been identified for recoupment.
Actual Recoup	**Actual Recoup** 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.
TED Adjustment	**TED Adjustment** is a dollar amount that is maintained by the system (not by the user) to accumulate TED adjustment or cancellations made during resolution of a duplicate claim. It is calculated as the sum of all adjustment and cancellation paid amounts that have been flagged by the user as being associated with correcting the duplicate. This is the sum of claim level paid amounts for institutional claims and line item paid amounts for non-institutional claims.
ID Recoup	**ID Recoup** is a dollar amount calculated by the system as the sum of **Identified Recoup** amounts for all claims within a set. It represents the total amount of overpayment for the claim set that has been identified for recoupment.
Actual Recoup	**Actual Recoup** is a dollar amount calculated by the system as the sum of claim level actual recoupment amounts for all claims within a set. It represents the total amount of overpayment for the set that has actually been recouped.
Adjust Amount	**Adjustment Amount** is a dollar amount calculated by the system as the sum of **TED Adjustment** 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.
Initial Load Date	**Initial Load Date** represents the date the claim set was initially loaded into the system. The LASTDATE reflects the most recent claim set update date - for specific types of updates.
Current Load Date	**Current Load Date** 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.

GENERATED DATA ELEMENTS (CONTINUED)	
FIELD NAME	**DESCRIPTION**
Last Update Date	**Last Update Date** represents the most recent date a claim set was updated. Changes to the following **will** change the **Last Update Date**: Status, Match Type, Multi-FI Indicator, Owner FI, Owner Region, ID Recoup, Actual Recoup, Set Adjustment Amount, and Adjust Indicator. The **Last Update Date** will **not** change solely due to a change to: User Defined Codes, Dupe? field, Solicited (**S?**) Indicator, TED Adjust?, Reason Code, Reason Code Explanation, or Notepad.
S?	**S?** is the Solicited Indicator. See *Section 5* for definition.
Set User Def	See *Section 5* for definition.

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
D103	Offset - Reissue	The duplicate payment was a result of an offset being cancelled and a new payment reissued.	No
D104	Stop Pay - Reissue	This duplicate payment was a result of the original check being stopped and the payment reissued.	No
D105	Stale Date - Reissue	This duplicate payment was a result of the original check stale dating and the payment reissued.	No
D200	System failed to detect and suspend as a potential duplicate.	The system did not recognize the claim as a potential duplicate.	Yes

REASON CODE	DESCRIPTION	EXPLANATION	ADDITIONAL EXPLANATION REQUIRED?
ACTUAL DUPLICATE REASON CODES (CONTINUED)			
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
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 TMA data base.	Yes
D208	Paid wrong provider.	The duplicate payment was a result of the initial payment being made to the wrong provider.	No
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 contractor.	No

REASON CODE	DESCRIPTION	EXPLANATION	ADDITIONAL EXPLANATION REQUIRED?
ACTUAL DUPLICATE REASON CODES (CONTINUED)			
D400	*TFL - Paid Primary in error.*	*Claim was erroneously processed and paid by MCSC instead of TDEFIC contractor*	*No*
D401	*TFL - Dupe logic failed to ID.*	*Claim processing dupe logic failed to ID as TFL claim*	*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	Same procedure codes/ different provider types (e.g., surgeon/assistant surgeon).	This is not a duplicate payment since the services paid on this claim are for assistant surgeon services were rendered by a different *provider or* type of provider than the *provider or* type of provider paid on the other claim(s).	No
N107	ECHO prorated Durable Equipment (DE)	This is not a duplicate payment since the services paid on this claim are for different ECHO prorated DE than that paid on the other claim(s).	No
N108	Technical or facility component/ professional component.	This is not duplicate payment since the services paid on this claim involve the technical or facility/professional services not paid on the other claim(s).	No

REASON CODE	DESCRIPTION	EXPLANATION	ADDITIONAL EXPLANATION REQUIRED?
NON-DUPLICATE REASON CODES (CONTINUED)			
N109	Same procedure codes but 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
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 issued to pay a different provider, or it reflects a payment issued under a previous suffix and a cancellation of the previous suffix has been issued or will be issued for the previous suffix, it is still a duplicate payment and the claim should be assigned "Y" **Dupe?** and an "Actual Duplicate Reason Code" used.	Yes

REASON CODE	DESCRIPTION	EXPLANATION	ADDITIONAL EXPLANATION REQUIRED?
NON-DUPLICATE REASON CODES (CONTINUED)			
N300	Claim belongs to FI 99	The claim belongs to FI 99. This non-duplicate reason code may be used to enable resolution of a set where the FI 99 claim is not the BASE claim. If the FI 99 claim is the BASE claim, the other claim(s) may be flagged with "Y" or "N" **Dupe?** and reason codes, recoupment amounts entered, and corresponding adjustments flagged as usual. If the FI 99 claim is not the BASE claim, it should be flagged with an "N" **Dupe?** and an N300 reason code. In either case, no FI 99 adjustments should be flagged.	No
N900	Other		Yes

INCOMING CONTRACTOR SUPPORT OF BOTH HCSR AND TED VERSIONS OF THE TRICARE DUPLICATE CLAIMS SYSTEM

This addendum describes the requirements for incoming contractors to operate both versions of the TRICARE Duplicate Claims System (DCS), that is, the HCSR and TED versions.

1.0. REQUIREMENTS FOR USE OF THE HCSR VERSION OF THE DCS

1.1. For incoming contractors, the TED version of the DCS will be their primary version. This is because the incoming contractors will be creating and submitting TED records and not HCSRs. However, incoming contractors will be inheriting, in accordance with the transition plans, non-*network DCS* sets from the outgoing contractors. These inherited sets are comprised of HCSRs, not TEDs. TMA is not converting HCSRs to TEDs. As a result, the incoming contractors must operate the HCSR as well as the TED version until all HCSR-related DCS actions are completed. It should be noted that TMA will be converting TED adjustment records to HCSRs. This permits the incoming contractor to adjust previously submitted HCSRs through a TED record.

1.2. In accordance with the DCS Contractor to Contractor Transition Guide in *Addendum D*, on the first day of the fourth month following the start of Services, TMA will initiate a mass change of the outgoing contractor's DCS sets. This mass change will transfer all of the outgoing contractor's non-*network* DCS sets (and any other DCS sets identified in the transition plan) to the incoming contractor. The sets transferred to the incoming contractor may contain sets in *Open* status, as well as sets in *Pending*, *Validate*, and *Closed* status. Any transferred sets in *Open* status must be researched by the incoming contractor and determinations made as to whether actual duplicate payments were made. Recoupments must be initiated on all claims identified as actual duplicates. This means that the incoming contractor must be able to read the HCSR data files transferred from the outgoing contractor by the first day of the fourth month following the start of Services in order to perform the required research and recoupments for sets appearing in the HCSR version of the DCS. *Note: In future transitions only non-financially underwritten DCS claim sets will be transferred to the incoming contractor.*

1.3. Any set in *Pending* or *Validate* status are awaiting recoupment. The incoming contractor will likely inherit such sets from the outgoing contractor. The outgoing contractor shall have forwarded all payment and recoupment files associated with in-progress non-*network* duplicate claim recoupments by the last day of the third month following the start of Services. Any refunds or offsets received by the incoming contractor that are associated with claims in *Pending* or *Validate* sets that were inherited, shall be entered into the HCSR version of the DCS. By the first day of the fourth month following the start of Services, the incoming contractor should have received and have access to all of the HCSR data and recoupment information necessary to work these sets. *Note: In future transitions only non-financially underwritten DCS claim sets will be transferred to the incoming contractor.*

1.4. For any refund or offset applied to claims in any inherited DCS set, the incoming contractor must submit an adjustment or cancellation TED record for a previously submitted HCSR. When TMA receives an adjustment or cancellation TED for a previously submitted HCSR record, it will convert it to a HCSR and load it to the HCSR version of the DCS. The incoming contractor will then be able to apply the adjustment to the claim in the set and resolve the set, if the rules of resolution are met.

1.5. Until all outgoing contracts are transitioned, incoming contractors should expect to see new sets appearing in the HCSR version of the DCS. This is because TMA will continue to identify potential duplicate claim sets from all HCSRs submitted. This will continue until all HCSR submissions cease and all payment records are being submitted in TED format. In addition to the sets transitioned from the outgoing contractor on the first day of the fourth month following the start of Services, the incoming contractor may receive new sets created from HCSRs submitted by the outgoing contractor for claims processed during the third month following the start of Services. Since the DCS system usually identifies and loads potential duplicate claim sets after the first day of the month, these sets may not have been included in the initial transfer occurring on the first day of the fourth month following the start of Services.

Also, incoming contractors should expect to see new multi-contractor sets in the HCSR version. These multi-contractor sets are created when a HCSR from an existing contractor "dupes out" with a HCSR whose ownership has been transferred and inherited by the incoming contractor.

1.6. TMA will not be comparing TED submissions with HCSR submissions to identify new potential duplicate payments. In other words, TED records submitted by the incoming contractor will not be matched with HCSRs currently or previously submitted by existing contractors. TED records will only be compared against other TED records. Also, any TED records converted to HCSRs will not be compared with other HCSRs for new potential duplicates. Only TED adjustments to previously submitted HCSRs will be loaded to the HCSR version of the DCS. These adjustments can then be used to resolve existing sets.

1.7. Incoming contractors should expect to see diminishing activity in the HCSR version of the DCS as existing contracts are transitioned to new incoming contractors. Once all contracts have been transitioned and all payment records are submitted in TED format, and all non-*network claim* sets have been resolved to a *Validate* or *Closed* status, the HCSR version will be retired and only the TED version will be used.

CONTRACTOR TO CONTRACTOR TRANSITION GUIDE

DATES	OUTGOING CONTRACTOR	TMA	INCOMING CONTRACTOR
Contract Award Through Start of Services	Continues to use the DCS to resolve potential duplicate claim sets.	Loads identifying and other information regarding the incoming contractor, the contract and region into the DCS. 30 - 45 days prior to the start of Services, TMA installs DCS software and trains the incoming contractor staff on the use of the DCS.	Purchases, configures and tests computer hardware, software and communications links required to operate the DCS no later than 60 days prior to the start of Services.
Start of Services Through The Last Day of The Third Month Following The Start of Services (*Three M*onths)	Continues to use the DCS to resolve potential duplicate claim sets.	TMA begins the ongoing process of identifying and loading potential duplicate claim sets associated with the incoming contractor. Within 60 days following Services, TMA prepares a "mass change" specification form which is to be executed on the first day of the fourth month after Services, for a "mass change" to transfer all potential duplicate claim sets involving non-financially underwritten claims from the outgoing contractor's DCS to the incoming contractor's DCS.	Incoming contractor begins using the DCS to resolve identified potential duplicate claim sets "owned" by the incoming contractor.
Note: This schedule shall be incorporated into the transition plans for the outgoing contractor and the incoming contractor. Actual dates shall be established in the transition plans.			

DATES	OUTGOING CONTRACTOR	TMA	INCOMING CONTRACTOR
Last Day of The Third Month Following The Start of Services	At the close of business, the outgoing contractor shall **cease** researching **non-financially underwritten** *Open* claim sets and initiating **new** recoupments associated with **non-financially underwritten** duplicate claim payments. The outgoing contractor shall also **cease** entering refund data and linking adjustment data in the DCS for *Pending* and *Validate* **non-financially underwritten** claim sets. The outgoing contractor shall continue using the DCS to perform **all** DCS functions for claim sets associated with **financially underwritten** claims including researching *Open* claim sets, initiating new recoupments, entering refund data and linking adjustment data.		Continues researching and resolving potential duplicate claim sets.
First Day of The Fourth Month Following Services	Beginning on the first day of the fourth month following Services, refund checks received and offsets taken for recoupments associated with **non-financially underwritten** duplicate claims payments and recoupment files associated with in progress **non-financially underwritten** duplicate claim recoupments shall be processed and forwarded to the incoming contractor in accordance with the Financial Procedures in the Transition Plan, the contract, and the Operations Manual.	A "mass change" is initiated transferring all of the outgoing contractor's **non-financially underwritten** DCS data to the incoming contractor's DCS.	Outgoing contractor's **non-financially underwritten** DCS data appears on the incoming contractor's DCS. Incoming contractor begins performing DCS research, recoupment, and resolution functions on **non-financially underwritten** potential duplicate claim sets transferred from the outgoing contractor as well as continuing to resolve their own duplicate claim sets.
Note: This schedule shall be incorporated into the transition plans for the outgoing contractor and the incoming contractor. Actual dates shall be established in the transition plans.			

DATES	OUTGOING CONTRACTOR	TMA	INCOMING CONTRACTOR
First Day of The Fourth Month Through The Last Day of HCSR *or TED* Submissions For The Outgoing Contractor (as defined by the transition schedule)	The outgoing contractor shall continue using the DCS to perform **all** DCS functions for claim sets associated with **financially underwritten** claims including researching *Open* claim sets and initiating new recoupments. The outgoing contractor shall have moved 100% of all *Open* DCS claim sets to a *Pending*, *Validate*, or *Closed* status by the last day of HCSR *or TED* submissions (as defined by the transition plan).	TMA prepares to have the outgoing contractor's passwords deleted from the DCS effective on the first day following the last day of HCSR *or TED* submissions for the outgoing contractor (as defined by the transition schedule). TMA shall generate monthly reports showing the status of the outgoing contractor's network claim sets.	Continues to research and resolve potential duplicate claim sets appearing on the DCS. By the last day of the **sixth month following Services**, the incoming contractor shall have completed the required research and have moved a sufficient number of *Open* sets to a *Pending*, *Validate*, or *Closed* status to ensure compliance with DCS performance standards which become effective for the incoming contractor on first day of the seventh month following Services.
First Day of The Seventh Month Following Services		Generates DCS reports to verify that the incoming contractor is in compliance with performance standards.	The DCS performance standards shall be in effect (see Chapter 1, Section 3, paragraph 6.0. for the DCS performance standards).
Last Day of HCSR *or TED* Submissions For The Outgoing Contractor (as defined by the transition schedule)	By the close of business, the outgoing contractor shall generate any DCS reports it wishes for its records.		Continues to research and resolve potential duplicate claim sets appearing on the DCS.
First Day Following The Last Day of HCSR *or TED* Submissions For The Outgoing Contractor (as defined by the transition schedule)	Outgoing contractor can no longer access the DCS.	Outgoing contractor's DCS passwords are deleted. TMA generates DCS management reports showing the status of all DCS sets owned by the outgoing contractor. TMA will change the Responsible FI of all claims from the outgoing contractor to FI 99. *Open* claim sets owned by FI 99 are moved to a *Closed* status. *Pending* claim sets owned by FI 99 are moved to a *Validate* status.	Continues to research and resolve potential duplicate claim sets appearing on the DCS.
Note: This schedule shall be incorporated into the transition plans for the outgoing contractor and the incoming contractor. Actual dates shall be established in the transition plans.			

REPORT DESCRIPTIONS AND EXAMPLES

REPORT CATEGORY:	Set Report
REPORT MENU HIERARCHY AND FORMAT NAME:	REPORT ⇒SET REPORTS ⇒**BASIC**
PRINTED REPORT TITLE:	Duplicate Claim System Sets Grouped by Set Number
REPORT DESCRIPTION:	This report provides set-level information regarding all of the sets loaded in the Duplicate Claim System. The fields displayed on the report are: Institutional/Non-Institutional Indicator; Set Number; Status; Set Match Type; Multi-Contractor Set? (Y/N); Owner FI; Region; Initial Load Date; Current Load Date; Last Update Date; Adjustments? (Y/N); Total Amount Idenified For Recoupment; Total Amount Actually Recouped; Total TED Adjustment Amount; and Set Level User Defined Code.
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 Set Level User Defined Codes.
REPORT NOTES:	The data used by this report format is set level data.

Status Code = All
Set Number = All
Set User Codes = All
Adjust Type = All
Owner Type = All
Claim Type =All
Match Type = All
Owner FI = All
Owner Region = All

Date: 4/12/05
Page 1

Duplicate Claim System Sets
Grouped By Set Number

50 - Acme Claims Processing

Undetermined Region

INSTITUTIONAL

SET #	STAT	MATCH TYPE	MULTI FI?	OWNER FI	REGION	INITIAL LOAD DATE	CURRENT LOAD DATE	LAST UPDATE DATE	ADJ?	ID RECOUP	ACTUAL RECOUP	ADJUSTMENT AMOUNT	USER CODE
6	C	D	N	50	MDA90504C0050	09/24/1996	12/16/1996	12/31/1996	N	$0.00	$0.00	$0.00	
15	O	N	N	50	MDA90504C0050	09/24/1996	09/24/1996	10/01/1996	Y	$0.00	$0.00	$0.00	
22	V	D	N	50	MDA90504C0050	09/24/1996	09/24/1996	10/02/1996	Y	$1,000.00	$1,000.00	$1,115.44	
INSTITUTIONAL TOTAL										$1,000.00	$1,000.00	$1,115.44	

NON-INSTITUTIONAL

SET #	STAT	MATCH TYPE	MULTI FI?	OWNER FI	REGION	INITIAL LOAD DATE	CURRENT LOAD DATE	LAST UPDATE DATE	ADJ?	ID RECOUP	ACTUAL RECOUP	ADJUSTMENT AMOUNT	USER CODE
121	O	E	N	50	MDA90504C00050	09/24/1996	01/24/1997	01/24/1997	Y	$0.00	$0.00	$0.00	
122	V	E	N	50	MDA90504C00050	09/24/1996	01/24/1997	01/24/1997	Y	$0.00	$0.00	$0.00	A4
123	O	E	N	50	MDA90504C00050	09/24/1996	01/24/1997	01/24/1997	Y	$0.00	$0.00	$0.00	
NON-INSTITUTIONAL TOTAL										$0.00	$0.00	$0.00	
Undetermined Region TOTAL										$1,000.00	$1,000.00	$1,115.44	
50 - Acme Claims Processing TOTAL										$1,000.00	$1,000.00	$1,115.44	

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REPORT CATEGORY:	Set Report
REPORT MENU HIERARCHY AND FORMAT NAME:	REPORT ⇒SET REPORTS ⇒**BASIC BY USER CODE**
PRINTED REPORT TITLE:	Duplicate Claim System Sets Grouped by User Code
REPORT DESCRIPTION:	This report provides set-level information regarding all of the sets loaded in the Duplicate Claim System grouped by Set Level User Defined Codes. The fields displayed on the report are: Institutional/Non-Institutional Indicator; Set Number; Status; Set Match Type; Multi-Contractor Set? (Y/N); Owner FI; Region; Initial Load Date; Current Load Date; Last Update Date; Adjustments? (Y/N); Total Amount Identified For Recoupment; Total Amount Actually Recouped; Total TED Adjustment Amount; and Set Level User Defined Code.
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 Set Level User Defined Codes.
REPORT NOTES:	The data used by this report format is set level data.

Status Code = All
Set User Codes = All
Adjust Type = All
Owner Type = All
Claim Type =All
Match Type = All
Owner FI = All
Owner Region = All
Set Number = All

Date: 4/12/05
Page 1

Duplicate Claim System Sets
Grouped By User Code

50 - Acme Claims Processing
Undetermined Region

A4 Test code a 4 am

NON-INSTITUTIONAL

SET #	STAT	MATCH TYPE	MULTI FI?	OWNER FI	REGION	INITIAL LOAD DATE	CURRENT LOAD DATE	LAST UPDATE DATE	ADJ?	ID RECOUP	ACTUAL RECOUP	ADJUSTMENT AMOUNT	USER CODE
122	V	E	N	50	MDA90504C0050	09/24/1996	01/24/1997	01/24/1997	Y	$0.00	$0.00	$0.00	A4
NON-INSTITUTIONAL Totals										**$0.00**	**$0.00**	**$0.00**	
A4 Test code a 4 am Totals										**$0.00**	**$0.00**	**$0.00**	

Blank User Code

INSTITUTIONAL

SET #	STAT	MATCH TYPE	MULTI FI?	OWNER FI	REGION	INITIAL LOAD DATE	CURRENT LOAD DATE	LAST UPDATE DATE	ADJ?	ID RECOUP	ACTUAL RECOUP	ADJUSTMENT AMOUNT	USER CODE
6	C	D	N	50	MDA90504C0050	09/24/1996	12/16/1996	12/31/1996	N	$0.00	$0.00	$0.00	
15	0	N	N	50	MDA90504C0050	09/24/1996	09/24/1996	10/01/1996	Y	$0.00	$0.00	$0.00	
22	V	D	N	50	MDA90504C0050	09/24/1996	09/24/1996	10/02/1996	Y	$1,000.00	$1,000.00	$1,115.44	
35	O	N	N	50	MDA90504C0050	09/24/1996	12/16/1996	12/16/1996	Y	$0.00	$0.00	$0.00	
36	O	D	N	50	MDA90504C0050	09/24/1996	12/16/1996	12/16/1996	Y	$0.00	$0.00	$0.00	
39	O	O	N	50	MDA90504C0050	09/24/1996	09/24/199	10/01/1996	Y	$0.00	$0.00	$0.00	
NON-INSTITUTIONAL Totals										**$1,000.00**	**$1,000.00**	**$1,115.44**	

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Status Code = All
Set User Codes = All
Adjust Type = All
Owner Type = All
Claim Type =All
Match Type = All
Owner FI = All
Owner Region = All
Set Number = All

Date: 4/12/05
Page 2

Duplicate Claim System Sets
Grouped By User Code

50 - Acme Claims Processing
Undetermined Region

Blank User Code

NON-INSTITUTIONAL

SET #	STAT	MATCH TYPE	MULTI FI?	OWNER FI	REGION	INITIAL LOAD DATE	CURRENT LOAD DATE	LAST UPDATE DATE	ADJ?	ID RECOUP	ACTUAL RECOUP	ADJUSTMENT AMOUNT	USER CODE
121	O	E	N	50	MDA90504C0050	09/24/1996	01/24/1997	01/24/1997	Y	$0.00	$0.00	$0.00	
123	O	E	N	50	MDA90504C0050	09/24/1996	01/24/1997	01/24/1997	Y	$0.00	$0.00	$0.00	
144	O	N	N	50	MDA90504C0050	09/24/1996	09/24/1996	09/24/1996	N	$0.00	$0.00	$0.00	
184	O	N	N	50	MDA90504C0050	09/24/1996	09/24/1996	09/24/1996	N	$0.00	$0.00	$0.00	
185	O	N	N	50	MDA90504C0050	09/24/1996	09/24/1996	09/24/1996	N	$0.00	$0.00	$0.00	
226	O	C	N	50	MDA90504C0050	09/24/1996	09/24/1996	10/01/1996	Y	$0.00	$0.00	$0.00	
NON-INSTITUTIONAL Totals										**$0.00**	**$0.00**	**$0.00**	
Blank User Code Totals										**$1,000.00**	**$1,000.00**	**$1,115.44**	
Undetermined Region Totals										**$1,000.00**	**$1,000.00**	**$1,115.44**	
50 - Acme Claims Processing Totals										**$1,000.00**	**$1,000.00**	**$1,115.44**	

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REPORT CATEGORY:	Set Report
REPORT MENU HIERARCHY AND FORMAT NAME:	REPORT ⇒SET REPORTS ⇒**USER LOG REPORT**
PRINTED REPORT TITLE:	User Log Grouped By Set Number (Transaction History)
REPORT DESCRIPTION:	This report identifies the users who made changes to a set and the dates on which the changes occurred. The fields displayed on the report are: Set Number; Status; Owner FI; Region; Initial Load Date; Current Load Date; Transaction Date; User ID; Total Amount Identified For Recoupment; Total Amount Actually Recouped; and Total TED Adjustment Amount. The report will identify all of the sets meeting the criteria selected on the report parameter screen and list all of the changes made to those sets along with the associated User Ids. The system detects changes to: the status of a set; the Owner FI; the Region; and the three total dollar amount fields. Whenever a change to one or more of these fields occurs, a "log" record is created and will appear on this report along with the User ID associated with the change(s). The report will not show log entries generated as a result of: sets to which claims have been added during the monthly load process; or sets that have been archived out of the active database to history. Users may see entries with an "System" or "CLAIMADD" as the User ID. These two User IDs are used by the DCS for set management purposes. These User Ids may appear when the system makes a change to a set. The report groups the data by Set Number in ascending order.
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 User IDs.
REPORT NOTES:	The data used by this report format is set level data.

Status Code = All
Adjust Type = All
Owner Type = All
Claim Type =All
Match Type = All
Set Number = All
Owner FI = All
Owner Region = All
User ID = All

Date: 5/12/05
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User Log Grouped By Set Number
(Transaction History)

Set Number	Stat	Owner FI	Region	Initial Load Date	Current Load Date	Transaction Date	User Id	Total Amount Ident Recoup	Total Amount Actual Recoup	Total Paid TED Adjustment
26809	C	##	AAAAAA	12/07/2004	12/07/2004	02/08/2005	jdoe	$65.38	$65.38	$0.00
26809	P	##	AAAAAA	12/07/2004	12/07/2004	02/08/2005	jdoe	$65.38	$65.38	$0.00
26809	O	##	AAAAAA	12/07/2004	12/07/2004	02/09/2005	jsmith	$0.00	$0.00	$0.00
26963	O	##	BBBBBB	02/07/2005	02/07/2005	02/08/2005	CLAIMADD	$0.00	$0.00	$0.00
26963	O	##	BBBBBB	02/07/2005	02/07/2005	02/17/2005	jdoe	$240.00	$0.00	$0.00
26963	O	###	AAAAAA	02/07/2005	02/07/2005	02/18/2005	SYSTEM	$240.00	$0.00	$0.00
32085	O	##	CCCCCC	02/07/2005	02/07/2005	02/08/2005	CLAIMADD	$0.00	$0.00	$0.00
32085	O	##	DDDDDD	02/07/2005	02/08/2005	02/08/2005	SYSTEM	$0.00	$0.00	$0.00
32085	O	##	AAAAAA	02/07/2005	02/18/2005	02/18/2005	SYSTEM	$0.00	$0.00	$0.00
32085	O	###	AAAAAA	02/07/2005	02/18/2005	04/01/2005	SYSTEM	$0.00	$0.00	$0.00
32981	O	##	CCCCCC	02/07/2005	02/07/2005	02/08/2005	CLAIMADD	$0.00	$0.00	$0.00
32981	O	##	CCCCCC	02/07/2005	02/07/2005	02/16/2005	jdoe	$36.85	$0.00	$0.00
32981	O	##	CCCCCC	02/07/2005	02/07/2005	02/17/2005	jdoe	$36.85	$15.00	$0.00
32981	O	##	CCCCCC	02/07/2005	02/07/2005	02/17/2005	jdoe	$36.85	$0.00	$0.00
32981	O	###	AAAAAA	02/07/2005	02/18/2005	02/18/2005	SYSTEM	$36.85	$0.00	$0.00
32981	p	###	AAAAAA	02/07/2005	02/18/2005	02/18/2005	jdoe	$36.85	$0.00	$0.00

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REPORT CATEGORY:	Set Report
REPORT MENU HIERARCHY AND FORMAT NAME:	REPORT ⇒SET REPORTS ⇒EXPLANATION REPORT ⇒ **NOTEPAD**
PRINTED REPORT TITLE:	*Explanations* Notepad
REPORT DESCRIPTION:	This report provides a listing of the notepad entries made on selected sets. The fields displayed on this report are: Set Number; Status; Match Type; Owner FI; Region; Initial Load Date; Current Load Date; and Notepad Entries.
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).
REPORT NOTES:	The data used by this report format is set level data.

Status Code = All
Adjust Type = All
Owner Type = All
Claim Type =All
Match Type = All
Owner FI = All
Owner Region = All
5 >= Set Number < = 8

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Explanations Notepad

50 - Acme Claims Processing

Set Number	Status	Match Type	Initial Load Date	Current Load Date
6	C	D	09/24/1996	12/16/1996

Testing the Notepad

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REPORT CATEGORY:	Set Report
REPORT MENU HIERARCHY AND FORMAT NAME:	REPORT ⇒SET REPORTS ⇒EXPLANATION REPORT ⇒ **VALIDATE**
PRINTED REPORT TITLE:	Validate Status Explanations
REPORT DESCRIPTION:	This report provides a listing of the explanations entered when sets are resolved to a *Validate* status. The Duplicate Claims System requires that an explanation be entered when a set is resolved to a *Validate* status. One of the required Validate explanations describes why the amount actually recouped and the paid amount of the TED adjustments submitted do not equal the amount identified for recoupment. The other required Validate explanation describes why all of the identified line-items of a non-institutional actual duplicate claim have not been adjusted. The fields displayed on this report are: Set Number; Status; Match Type; Owner FI; Region; Initial Load Date; Current Load Date; and Validate Explanations.
REPORT PARAMETER OPTIONS:	Users may customize the report by selecting: All "Standard" parameters minus Claim Set Status (Adjustments, Set Owner Type, Claim Type, Match Type, Date Type, Set Range, FI, Region).
REPORT NOTES:	The data used by this report format is set level data.

Adjust Type = All
Owner Type = All
Claim Type =All
Match Type = All
Set Number = All
Owner FI = All
Owner Region = All

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Validate Status Explanations

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REPORT CATEGORY:	Set Report
REPORT MENU HIERARCHY AND FORMAT NAME:	REPORT ⇒SET REPORTS ⇒EXPLANATION REPORT ⇒ **MODIFY**
PRINTED REPORT TITLE:	Modify FI Explanations
REPORT DESCRIPTION:	This report provides a listing of the explanations entered when the Owner FI is changed on multi-contractor sets. The Duplicate Claims System requires that an explanation be entered when ownership of a multi-contractor set is changed from one contractor to another. The explanation entered should indicate who changed set ownership, who the change was discussed with at the receiving contractor, the date the discussions and the change took place, and why ownership was changed. The fields displayed on the report are: Set Number; Status; Match Type; Owner FI; Region; Initial Load Date; Current Load Date; and the Modify FI Explanations.
REPORT PARAMETER OPTIONS:	Users may customize the report by selecting: All "Standard" parameters minus Owner Type (Claim Set Status; Adjustments, Claim Type, Match Type, Date Type, Set Range, FI, Region).
REPORT NOTES:	The data used by this report format is set level data.

Status Code = All
Adjust Type = All
Claim Type =All
Match Type = All
Set Number = All
Owner FI = All
Owner Region = All

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Modify FI Explanations

50 - Acme Claims Processing

Undetermined

Set Number	Status	Match Type	Initial Load Date	Current Load Date
63	O	N	09/24/1996	12/16/1996
Transferred iaw telcon 6/5/97				
371	O	E	09/24/1996	12/16/1996
Jurisdictional error, transfer coordinated				
578	O	N	09/24/1996	01/28/1997
transfer coordinated 7/11/97				

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REPORT CATEGORY:	Set Report
REPORT MENU HIERARCHY AND FORMAT NAME:	REPORT ⇒SET REPORTS ⇒**REGION UNASSIGNED**
PRINTED REPORT TITLE:	Multi-Contractor Sets Region Missing
REPORT DESCRIPTION:	This report provides a listing of the multi-contractor sets in the Duplicate Claims System for which a region has not been assigned. All sets are assigned a region when they are loaded into the system and when mass changes occur. When ownership of a multi-contractor set is changed from one contractor to another, the receiving contractor must assign the applicable region to the set. If the receiving contractor does not assign a region, the set cannot be associated with a particular contract. This report will provide receiving contractors with a listing of the sets which have not had regions assigned. The fields displayed on the report are: Set Number; Status; Initial Load Date; Current Load Date; and Owner FI.
REPORT PARAMETER OPTIONS:	Users may customize the report by selecting: All "Standard" parameters minus Owner Type and Set Range (Claim Set Status; Adjustments, Claim Type, Match Type, Date Type, FI, Region).
REPORT NOTES:	The data used by this report format is set level data.

Status Code = All
Adjust Type = All
Claim Type =All
Match Type = All
Owner FI = All
Owner Region = All

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Multi Contractor Sets
Region Missing

Set Number	Owner FI	Status	Initial Load Date	Current Load Date
21 - Grand Army Health Care				
33676	21	O	02/07/2005	03/25/2005
22 - Excel Health Care				
33290	22	O	02/07/2005	03/25/2005
33504	22	O	02/07/2005	03/25/2005
23 - Seven Health Care				
162	23	V	11/22/2004	11/22/2004

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REPORT CATEGORY:	Set Report
REPORT MENU HIERARCHY AND FORMAT NAME:	REPORT ⇒SET REPORTS ⇒**SET COUNTS BY REGION**
PRINTED REPORT TITLE:	Set Counts By Region
REPORT DESCRIPTION:	This report provides the numbers of sets of each match type by contract region. The report shows the number of sets of each match type, the percentage each match type represents of the total number of sets for the region, the number of sets for each match type which have associated adjustments, and the percentage of each match type which have been adjusted. This report will show the distribution of sets for a region across match types. It will also show the user how many sets in a given match type category have associated adjustments and the percentage of that match type category which have adjustments. This report can serve as a tool for contractors to help diagnose causes for duplicate payments and to help determine workload and needed resources.
REPORT PARAMETER OPTIONS:	Users may customize the report by selecting: All "Standard" parameters minus Match Type and Set Range (Claim Set Status; Adjustments, Claim Type, Date Type, FI, Region) plus Set Level User Defined Codes.
REPORT NOTES:	The data used by this report format is set level data.

Status Code = All
Adjust Type = All
Claim Type =All
Match Type = All
Set Number = All
Owner FI = All
Owner Region = All

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Set Counts By Region

50 - Acme Claims Processing

Undetermined

Match Type	# of Sets	% of Total	# of Adjusted Sets	% Adjusted
CPT-4 Code	4	3.74%	4	100.00%
Date Overlap	23	21.50%	17	73.91%
Exact	35	32.71%	32	91.43%
Near	29	27.10%	19	65.52%
Other	16	14.95%	9	56.25%
Region Totals	**107**	**100.00%**	**81**	**75.70%**
FI Totals	**107**	**100.00%**	**81**	**75.70%**

55 - East West Claims

Area 55

Match Type	# of Sets	% of Total	# of Adjusted Sets	% Adjusted
Exact	1	100.00%	1	100.00%
Region Totals	**1**	**100.00%**	**1**	**100.00%**
FI Totals	**1**	**100.00%**	**1**	**100.00%**

73 - HAL Systems Inc

Area 73A

Match Type	# of Sets	% of Total	# of Adjusted Sets	% Adjusted
Date Overlap	1	100.00%	1	100.00%
Region Totals	**1**	**100.00%**	**1**	**100.00%**
FI Totals	**1**	**100.00%**	**1**	**100.00%**

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Status Code = All
Adjust Type = All
Claim Type =All
Match Type = All
Set Number = All
Owner FI = All
Owner Region = All

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Set Counts By Region

99 - Inactive Contractor

Inactive-Area 20

Match Type	# of Sets	% of Total	# of Adjusted Sets	% Adjusted
Near	1	100.00%	1	100.00%
Region Totals	**1**	**100.00%**	**1**	**100.00%**
FI Totals	**1**	**100.00%**	**1**	**100.00%**

Inactive -Area 30

Match Type	# of Sets	% of Total	# of Adjusted Sets	% Adjusted
Near	1	100.00%	1	100.00%
Region Totals	**1**	**100.00%**	**1**	**100.00%**
FI Totals	**1**	**100.00%**	**1**	**100.00%**
Grand Totals	**111**	**100.00%**	**84**	**75.68%**

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REPORT CATEGORY:	Set Report
REPORT MENU HIERARCHY AND FORMAT NAME:	REPORT ⇒SET REPORTS ⇒**SET LEVEL USER CODES**
PRINTED REPORT TITLE:	Set Level User Defined Field Definitions
REPORT DESCRIPTION:	This report displays the Owner FI, the Set 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 set level data.

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Set Level User Defined Field Definitions

Owner FI	Contract #	Code	Description	Active ?
50	MDA90504C0050	A4	Test code a 4 am	Y
51	MDA90504C0051	A4	testing	Y
51	MDA90504C0051	1A	Testy - 1A	Y
51	MDA90504C0051	2B	TEST - 2B	Y
52	58	2L	Test 232	Y
52	93D0004	86	testing	N
52	MDA90504C0052	86	testing	Y
52	94D0004	44	testing	Y
52	88D0006	45	TEST	Y
52	89D0002	2A	TEST	Y
54	88D0004	2E	Test	Y
54	89D0004	55	tesyting	Y
55	MDA90504C0055	B3	Test Code B 31	Y
56	88D0004	56	testing	Y
56	93D0004	2C	TEST	Y
73	89D0002	2F	Tst	Y
73	89D0002	2G	TEST	Y

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REPORT CATEGORY:	Claim Report
REPORT MENU HIERARCHY AND FORMAT NAME:	REPORT ⇒CLAIM REPORTS ⇒**BASIC**
PRINTED REPORT TITLE:	Basic Duplicate Claim Report Institutional and Non-Institutional Claim and Line Item Level Data
REPORT DESCRIPTION:	This report lists all of the claims loaded in the system grouped by claim number. The report will show institutional and non-institutional claims. This report format will allow the user to select by Duplicate Flag values. The fields displayed on the report are: Owner FI; ICN; Claim Level User Defined Code; Solicited Indicator; Set Number; Duplicate Flag Value; Reason Code; Processed-To-Completion Date; Responsible FI Number; Sponsor *ID*; *Patient ID;* Patient Name; Amount Billed; Amount Paid; Amount Identified For Recoupment; Amount Actually Recouped. For Non-Institutional claims, line item data will also be displayed. The line item fields displayed include: Line Item Number; Line Item Match Type; Procedure Code; *Provider Tax ID; Provider Sub-ID;* Place of Service; Type of Service; Care Begin Date; Care End Date; Line Item Amount Billed for the Procedure; and Amount Paid for the Procedure. The report identifies and prints all of the claims occurring in sets meeting the criteria selected on the report parameter screen.
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 Dupe Flag Indicator; Solicited Indicator; Exclude Base; PTC Date; Set Level User Defined Codes; Claim Level User Defined Codes; Responsible FI; Region*; and Enrollment Codes*.
REPORT NOTES:	The data used by this report format is claim level and line item level data. If a non-institutional claim exists in more than one set, it will print for each set in which it exists. Each instance of these non-institutional claims existing in multiple sets will contain a different set number on the report.

Status Code = All
Adjust Type = All
Owner Type = All
Claim Type = All
Match Type = All
Owner FI = All
Owner Region = All
Resp FI = All
Resp Region = All
Dupe Flag = All
Set Number = All
Set User Codes = All
Exclude Base Claims = No
Solicited = All
Claim User Codes = All
Enroll Codes = All

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Basic Duplicate Claim Report
Institutional And Non-Institutional
Claim & Line Item Level Data

50 - Acme Claims Processing

ICN	USR CD	S ?	SET#	DUP FLG	RSN CODE	PTC DATE	RESP FI	SPON ID	PATIENT ID	PATIENT NAME	PROVIDER TAX ID	PROV SUB-ID	AMT BILLED	AMT GOVT PAID	AMT ID RECOUP	AMT ACTUAL RECOUP
19940462508505			251	N	BASE	3/10/1994	50	999999999	9999999990	SMITH,LESLIE,X	555555555	0000	$2,175.00	$933.37	$0.00	$0.00

Li#	M Type	CPT-4	Provider Tax ID	Prov Sub ID	POS	TOS	Care Begin Date	Care End	Amt. Billed CPT-4	Govt PD Amt CPT-4
4	C	99221			21	I1	7/20/1992	7/20/1992	$150.00	$90.70

ICN	USR CD	S ?	SET#	DUP FLG	RSN CODE	PTC DATE	RESP FI	SPON ID	PATIENT ID	PATIENT NAME	PROVIDER TAX ID	PROV SUB-ID	AMT BILLED	AMT GOVT PAID	AMT ID RECOUP	AMT ACTUAL RECOUP
19940462508505			252	N	BASE	3/10/1994	50	999999999	9999999990	SMITH,LESLIE,X	555555555	0000	$2,175.00	$933.37	$0.00	$0.00

Li#	M Type	CPT-4	Provider Tax ID	Prov Sub ID	POS	TOS	Care Begin Date	Care End	Amt. Billed CPT-4	Govt PD Amt CPT-4
3	E	99232			21	I1	7/21/1992	7/24/1992	$450.00	$385.20

ICN	USR CD	S ?	SET#	DUP FLG	RSN CODE	PTC DATE	RESP FI	SPON ID	PATIENT ID	PATIENT NAME	PROVIDER TAX ID	PROV SUB-ID	AMT BILLED	AMT GOVT PAID	AMT ID RECOUP	AMT ACTUAL RECOUP
19940462508505			253	N	BASE	3/10/1994	50	999999999	9999999990	SMITH,LESLIE,X	555555555	0000	$2,175.00	$933.37	$0.00	$0.00

Li#	M Type	CPT-4	Provider Tax ID	Prov Sub ID	POS	TOS	Care Begin Date	Care End	Amt. Billed CPT-4	Govt PD Amt CPT-4
1	N	43235			21	I2	7/22/1992	7/22/1992	$575.00	$327.00

ICN	USR CD	S ?	SET#	DUP FLG	RSN CODE	PTC DATE	RESP FI	SPON ID	PATIENT ID	PATIENT NAME	PROVIDER TAX ID	PROV SUB-ID	AMT BILLED	AMT GOVT PAID	AMT ID RECOUP	AMT ACTUAL RECOUP
19940462508505			254	N	BASE	3/10/1994	50	999999999	9999999990	SMITH,LESLIE,X	555555555	0000	$2,175.00	$933.37	$0.00	$0.00

Li#	M Type	CPT-4	Provider Tax ID	Prov Sub ID	POS	TOS	Care Begin Date	Care End	Amt. Billed CPT-4	Govt PD Amt CPT-4
2	N	45378			21	I2	7/27/1992	7/27/1992	$1,000.00	$441.60

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REPORT CATEGORY:	Claim Report
REPORT MENU HIERARCHY AND FORMAT NAME:	REPORT ⇒CLAIM REPORTS ⇒**BASIC BY SET**
PRINTED REPORT TITLE:	Basic Duplicate Claim Report By Set Institutional and Non-Institutional Claim and Line Item Level Data
REPORT DESCRIPTION:	This report lists all of the claims loaded in the system grouped by set number. The report will show institutional and non-institutional claims. This report format will allow the user to select by Duplicate Flag values. The fields displayed on the report are: Owner FI; ICN; Claim Level User Defined Code; Solicited Indicator; Set Number; Duplicate Flag Value; Reason Code; Processed-To-Completion Date; Responsible FI Number; Sponsor *ID*; *Patient ID;* Patient Name; Amount Billed; Amount Paid; Amount Identified For Recoupment; Amount Actually Recouped. For Non-Institutional claims, line item data will also be displayed. The line item fields displayed include: Line Item Number; Line Item Match Type; Procedure Code; *Provider Tax ID; Provider Sub-ID;* Place of Service; Type of Service; Care Begin Date; Care End Date; Line Item Amount Billed for the Procedure; and Amount Paid for the Procedure. The report identifies and prints all of the claims occurring in sets meeting the criteria selected on the report parameter screen.
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 Dupe Flag Indicator; Solicited Indicator; Exclude Base; PTC Date; Set Level User Defined Codes; Claim Level User Defined Codes; Responsible FI*;* and Region.
REPORT NOTES:	The data used by this report format is claim level and line item level data. If a non-institutional claim exists in more than one set, it will print for each set in which it exists. Each instance of these non-institutional claims existing in multiple sets will contain a different set number on the report.

Status Code = All
Adjust Type = All
Owner Type = All
Claim Type = All
Match Type = All
Owner FI = All
Owner Region = All
Resp FI = All
Resp Region = All
Dupe Flag = All
Set Number = All
Set User Codes = All
Exclude Base Claims = No
Solicited = All
Claim User Codes = All
Enroll Codes = All

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Basic Duplicate Claim Report by Set
Institutional And Non-Institutional
Claim & Line Item Level Data

50 - Acme Claims Processing

SET#	ICN	USR CD	S ?	DUP FLG	RSN CODE	PTC DATE	RESP FI	SPON ID	PATIENT ID	PATIENT NAME	PROVIDER TAX ID	PROV SUB-ID	AMT BILLED	AMT GOVT PAID	AMT ID RECOUP	AMT ACTUAL RECOUP
79862	19962044104011			Y		8/14/1996	50	999999999	9999999990	SMITH,LESLIE,X	555555555	0000	$625.00	$69.28	$0.00	$0.00

Li#	M Type	CPT-4	Provider Tax ID	Prov Sub ID	POS	TOS	Care Begin Date	Care End	Amt. Billed CPT-4	Govt PD Amt CPT-4
1	O	42100			11	O2	6/19/1996	6/19/19996	$510.00	$81.28

SET#	ICN	USR CD	S ?	DUP FLG	RSN CODE	PTC DATE	RESP FI	SPON ID	PATIENT ID	PATIENT NAME	PROVIDER TAX ID	PROV SUB-ID	AMT BILLED	AMT GOVT PAID	AMT ID RECOUP	AMT ACTUAL RECOUP
79862	19962494100571			N	N103	11/05/1996	50	999999999	9999999990	SMITH,LESLIE,X	555555555	0000	$625.00	$335.19	$0.00	$0.00

Li#	M Type	CPT-4	Provider Tax ID	Prov Sub ID	POS	TOS	Care Begin Date	Care End	Amt. Billed CPT-4	Govt PD Amt CPT-4
1	O	42100			11	O7	6/19/1996	6/19/19996	$300.00	$254.03
2	O	42100			11	O2	6/19/1996	6/19/19996	$210.00	$81.28

99 - Inactive Contractor

SET#	ICN	USR CD	S ?	DUP FLG	RSN CODE	PTC DATE	RESP FI	SPON ID	PATIENT ID	PATIENT NAME	PROVIDER TAX ID	PROV SUB-ID	AMT BILLED	AMT GOVT PAID	AMT ID RECOUP	AMT ACTUAL RECOUP
22221	19951000627827			N	BASE	4/24/1995	99	999999999	9999999990	SMITH,LESLIE,X	555555555	0000	$1,860.00	$1,075.28	$0.00	$0.00

Li#	M Type	CPT-4	Provider Tax ID	Prov Sub ID	POS	TOS	Care Begin Date	Care End	Amt. Billed CPT-4	Govt PD Amt CPT-4
1	N	99214			11	O1	2/28/1995	2/28/1995	$70.00	$53.45
2	N	93000			11	O1	2/28/1995	2/28/1995	$75.00	$31.32
3	N	93307			11	O1	2/28/1995	2/28/1995	$400.00	$255.77

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REPORT CATEGORY:	Claim Report
REPORT MENU HIERARCHY AND FORMAT NAME:	REPORT ⇒CLAIM REPORTS ⇒**INSTITUTIONAL**
PRINTED REPORT TITLE:	Institutional Claims
REPORT DESCRIPTION:	This report lists institutional claims grouped by current set status. This report lists institutional claims within their respective sets. The fields displayed on the report are: Owner FI; Institutional Indicator; Status Code; Set Number; ICN; Claim Level User Defined Code; Solicited Indicator; Dupe Flag Indicator; Processed to Completion Date; Responsible FI Number; Sponsor *ID*; *Patient ID;* Patient Name; Date of Birth; Provider *Nbr*; Provider Sub-ID; Amount Billed; Amount *Allowed*; and Government Paid 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 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; Region*; and Enrollment Codes*.
REPORT NOTES:	The data used by this report format is claim level data. The billed and net Government paid amounts are claim level dollar amounts.

Status Code = All
Adjust Type = All
Owner Type = All
Match Type = All
Dupe Flag = All
Set Number = All
Owner FI = All
Owner Region = All
Resp FI = All
Resp Region = All
Exclude Base Claims = No
Enroll Codes = All
Solicited = All
Set User Codes = All
Claim User Codes = All

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Institutional Claims

50 - Acme Claims Processing

INSTITUTIONAL

Status Code :C

SET #	ICN	USR CD	S ?	DUP FLG	PTC DATE	RS FI	SPON ID	PATIENT ID	PATIENT NAME	DOB	PROVIDER NUMBER	PROV SUB-ID	AMT BILLED	AMT ALLOWED	AMT GOVT PAID
6	19942624830562			N	9/22/1994	50	999999999	9999999990	SMITH,LESLIE,X	11/16/1982	55555555	0000	$6,080.00	$1,739.29	$1,739.29
6	19942694832217				9/28/1994	50	999999999	9999999990	SMITH,LESLIE,X	11/16/1982	55555555	0000	$4,425.00	$1,304.46	$1,304.46
23747	19941170620950			N	6/30/1994	50	999999999	9999999990	SMITH,LESLIE,X	7/22/1980	55555555	0001	$19,236.00	$19,236.00	$18,458.00
23747	19942000640016				7/21/1994	99	999999999	9999999990	SMITH,LESLIE,X	7/22/1980	55555555	0001	$12,868.30	$8,148.00	$7,259.90
									Status Totals				$42,609.30	$30,427.75	$28,761.65

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Status Code = All
Adjust Type = All
Owner Type = All
Match Type = All
Dupe Flag = All
Set Number = All
Owner FI = All
Owner Region = All
Resp FI = All
Resp Region = All
Exclude Base Claims = No
Enroll Codes = All
Solicited = All
Set User Codes = All
Claim User Codes = All

Date: 4/29/05
Page 2

Institutional Claims

50 - Acme Claims Processing

INSTITUTIONAL

Status Code :V

SET #	ICN	USR CD	S ?	DUP FLG	PTC DATE	RS FI	SPON ID	PATIENT ID	PATIENT NAME	DOB	PROVIDER NUMBER	PROV SUB-ID	AMT BILLED	AMT ALLOWED	AMT GOVT PAID
15	19941882424012			N	7/15/1994	50	999999999	9999999990	SMITH,LESLIE,X	1/06/1932	55555555	0000	$8,353.93	$431.50	$431.50
15	19941882424013				7/25/1994	50	999999999	9999999990	SMITH,LESLIE,X	1/06/1932	55555555	0000	$7,000.00	$350.00	$350.00
22	19933335170207			Y	7/15/1994	50	999999999	9999999990	SMITH,LESLIE,X	5/31/1972	55555555	0000	$2,763.05	$1,115.44	$1,090.44
22	19942575143500			N	7/25/1994	50	999999999	9999999990	SMITH,LESLIE,X	5/31/1972	55555555	0000	$2,936.87	$1,115.44	$1,087.54
Status Totals													$21,053.85	$3,012.38	$2,959.48
Contractor Totals													$63,663.15	$33,440.13	$31,721.13

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Status Code = All
Adjust Type = All
Owner Type = All
Match Type = All
Dupe Flag = All
Set Number = All
Owner FI = All
Owner Region = All
Resp FI = All
Resp Region = All
Exclude Base Claims = No
Enroll Codes = All
Solicited = All
Set User Codes = All
Claim User Codes = All

Date: 4/29/05
Page 3

Institutional Claims

73 - HAL Systems Inc

INSTITUTIONAL

Status Code :O

SET #	ICN	USR CD	S ?	DUP FLG	PTC DATE	RS FI	SPON ID	PATIENT ID	PATIENT NAME	DOB	PROVIDER NUMBER	PROV SUB-ID	AMT BILLED	AMT ALLOWED	AMT GOVT PAID
3461	19940474270059			N	3/04/1994	73	999999999	9999999990	SMITH,LESLIE,X	2/04/1994	55555555	0000	$28,859.00	$28,859.00	$28,803.20
3461	19940474270059			N	3/04/1994	73	999999999	9999999990	SMITH,LESLIE,X	2/04/1994	55555555	0000	$28,859.00	$28,859.00	$28,803.20
3461	19940474270059			N	3/04/1994	73	999999999	9999999990	SMITH,LESLIE,X	2/04/1994	55555555	0000	$28,859.00	$28,859.00	$28,803.20
Status Totals													$89,539.40	$53,450.92	$53,395.12
Contractor Totals													$89,539.40	$53,450.92	$53,395.12
Report Totals													$153,202.55	$86,891.05	$85,116.25

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REPORT CATEGORY:	Claim Report
REPORT MENU HIERARCHY AND FORMAT NAME:	REPORT ⇒CLAIM REPORTS ⇒NON-INSTITUTIONAL ⇒**BY CLAIM**
PRINTED REPORT TITLE:	Non-Institutional Claims
REPORT DESCRIPTION:	This report lists non-institutional claims grouped by current set status. This report lists non- institutional claims within their respective sets. The fields displayed on the report are: Owner FI; Region; Set Status Code; ICN; Claim Level User Defined Code; Solicited Indicator; Set Number; Dupe Flag Indicator; Processed to Completion Date; Responsible FI; Sponsor *ID*; *Patient ID;* Patient Name; Date of Birth; Amount Billed; Amount *Allowed*; and Government Paid 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 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, Processed To Completion date, Care dates, Set Level User Defined Codes, Claim Level User Defined Codes, Responsible FI, Region*, and Enrollment Codes*.
REPORT NOTES:	The data used by this report format is claim level data. The billed, paid and net Government paid amounts are claim level not line-item level dollar amounts.

Status Code = All
Adjust Type = All
Owner Type = All
Match Type = All
Dupe Flag = All
Set Number = All
Solicited = All
Owner FI = All
Owner Region = All
Resp FI = All
Resp Region = All
Set User Codes = All
Claim User Codes = All
Exclude Base Claims = No
Enroll Codes = All

Date: 4/29/05
Page 1

Non-Institutional Claims

50 - Acme Claims Processing

Undetermined Region

Status Code: O

ICN	USR CD	S ?	SET #	DUP FLG	PTC DATE	RS FI	SPON ID	PATIENT ID	PATIENT NAME	DOB	AMT BILLED	AMT ALLOWED	AMT GOVT PAID
19963123242029			76070		11/15/1996	50	999999999	9999999990	SMITH,LESLIE,X	11/01/1932	$2,700.00	$1,005.60	$754.20
19960814823188			76527	N	8/02/1996	50	999999999	9999999990	SMITH,LESLIE,X	9/23/1937	$681.00	$177.34	$165.34
19963024810904			76527		11/04/1996	50	999999999	9999999990	SMITH,LESLIE,X	9/23/1937	$681.00	$177.34	$165.34

Status Totals	$4,062.00	$1, 084.88
		$1,360.28

Status Code: V

ICN	USR CD	S ?	SET #	DUP FLG	PTC DATE	RS FI	SPON ID	PATIENT ID	PATIENT NAME	DOB	AMT BILLED	AMT ALLOWED	AMT GOVT PAID
19941925400374	B4		122	N	7/25/1994	50	999999999	9999999990	SMITH,LESLIE,X	9/28/1899	$455.00	$307.10	$230.32

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Status Code = All
Adjust Type = All
Owner Type = All
Match Type = All
Dupe Flag = All
Set Number = All
Solicited = All
Owner FI = All
Owner Region = All
Resp FI = All
Resp Region = All
Set User Codes = All
Claim User Codes = All
Exclude Base Claims = No
Enroll Codes = All

Date: 4/29/05
Page 2

Non-Institutional Claims

50 - Acme Claims Processing

Undetermined Region

Status Code: V

ICN	USR CD	S ?	SET #	DUP FLG	PTC DATE	RS FI	SPON ID	PATIENT ID	PATIENT NAME	DOB	AMT BILLED	AMT ALLOWED	AMT GOVT PAID
19942065400200	B4		122		8/10/1994	50	999999999	9999999990	SMITH,LESLIE,X	9/28/1899	$455.00	$307.10	$230.32

Status Totals	$910.00	$614.20	$460.64
Region Totals	$4,972.00	$1,974.48	$1,545.52
Contractor Totals	$4,972.00	$1,974.48	$1,545.52

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Status Code = All
Adjust Type = All
Owner Type = All
Match Type = All
Dupe Flag = All
Set Number = All
Solicited = All
Owner FI = All
Owner Region = All
Resp FI = All
Resp Region = All
Set User Codes = All
Claim User Codes = All
Exclude Base Claims = No
Enroll Codes = All

Date: 4/29/05
Page 3

Non-Institutional Claims

99 - Inactive Contractor

Inactive-Area 20

Status Code: O

ICN	USR CD	S ?	SET #	DUP FLG	PTC DATE	RS FI	SPON ID	PATIENT ID	PATIENT NAME	DOB	AMT BILLED	AMT ALLOWED	AMT GOVT PAID
19951000627827			22221	N	4/24/1995	99	999999999	9999999990	SMITH,LESLIE,X	9/20/1948	$1,860.00	$1,090.56	$1,075.56
19951240640035			22221		05/11/1995	99	999999999	9999999990	SMITH,LESLIE,X	9/20/1948	$400.00	$229.63	$229.63
19951240640036			22221		05/11/1995	99	999999999	9999999990	SMITH,LESLIE,X	9/20/1948	$1,245.00	$721.78	$721.78

Status Totals	$3,505.00	$2,041.97	$2,026.97
Region Totals	$3,505.00	$2,041.97	$2,026.97
Contractor Totals	$3,505.00	$2,041.97	$2,026.97
Grand Totals	$8,477.00	$4,016.45	$3,572.49

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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; Claim Level User Defined Code; Solicited Indicator; Set Number; Responsible FI; Sponsor *ID*; *Patient ID;* Patient Name; Provider *Number*; 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; Region*; and Enrollment Codes*.
REPORT NOTES:	The data used by this report format is line item level data. The paid amounts are line item level dollar amounts.

Status Code = All
Owner Type = All
Adjust Type = All
Match Type = All
Dupe Flag = All
Solicited = All
Set Number = All
Owner FI = All
Owner Region = All
Resp FI = All
Resp Region = All
Exclude Base Claims = No
Set User Codes = All
Claim User Codes = All
Enroll Codes = All

Date: 4/29/05
Page 1

Non-Institutional Claims By Line Item

50 - Acme Claims Processing

Undetermined Region

Status Code: O

ICN	USR CD	S?	SET #	RESP FI	SPON ID	PATIENT ID	PATIENT NAME	PROVIDER NUMBER	PROV SUB-ID	LI	CPT-4 CODE	CARE BEGIN	CARE END	AMT GOVT PD CPT-4 CODE
19962044104011			79862	50	999999999	9999999990	SMITH,LESLIE,X			1	42100	06/19/1996	06/19/1996	$81.28
19962494100571			79862	50	999999999	9999999990	SMITH,LESLIE,X			1	42100	06/19/1996	06/19/1996	$254.03
19962494100571			79862	50	999999999	9999999990	SMITH,LESLIE,X			2	42100	06/19/1996	06/19/1996	$81.28
											Status Total			$416.59

Status Code: V

ICN	USR CD	S?	SET #	RESP FI	SPON ID	PATIENT ID	PATIENT NAME	PROVIDER NUMBER	PROV SUB-ID	LI	CPT-4 CODE	CARE BEGIN	CARE END	AMT GOVT PD CPT-4 CODE
19941925400374	B4		122	50	999999999	9999999990	SMITH,LESLIE,X			2	99231	04/22/1994	04/22/1994	$125.08
19942065400200	B4		122	50	999999999	9999999990	SMITH,LESLIE,X			3	99231	04/22/1994	04/22/1994	$254.03
											Status Total			$250.16
											Region Total			$666.75
											Contractor Total			$666.75

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Status Code = All
Owner Type = All
Adjust Type = All
Match Type = All
Dupe Flag = All
Solicited = All
Set Number = All
Owner FI = All
Owner Region = All
Resp FI = All
Resp Region = All
Exclude Base Claims = No
Set User Codes = All
Claim User Codes = All
Enroll Codes = All

Date: 4/29/05
Page 2

Non-Institutional Claims By Line Item

99 - Inactive Contractor

Inactive-Area 20

Status Code: O

ICN	USR CD	S?	SET #	RESP FI	SPON ID	PATIENT ID	PATIENT NAME	PROVIDER NUMBER	PROV SUB-ID	LI	CPT-4 CODE	CARE BEGIN	CARE END	AMT GOVT PD CPT-4 CODE
19951000627827			22221	99	999999999	9999999990	SMITH,LESLIE,X			1	99214	02/28/1995	02/28/1995	$53.45
19951000627827			22221	99	999999999	9999999990	SMITH,LESLIE,X			2	93000	02/28/1995	02/28/1995	$31.32
19951000627827			22221	99	999999999	9999999990	SMITH,LESLIE,X			3	93307	02/28/1995	02/28/1995	$255.77
19951000627827			22221	99	999999999	9999999990	SMITH,LESLIE,X			4	93320	02/28/1995	02/28/1995	$134.97

Status Total	$475.51
Region Total	$475.51
Contractor Total	$475.51
Grand Total	$1,142.26

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REPORT CATEGORY:	Claim Report
REPORT MENU HIERARCHY AND FORMAT NAME:	REPORT ⇒CLAIM REPORTS ⇒RISK ⇒**RISK BASIC**
PRINTED REPORT TITLE:	Risk Report By ICN
REPORT DESCRIPTION:	This report provides a listing of claims based on the Risk Indicator values selected by the user. The Risk Indicator identifies the claim as either financially underwritten or non-financially underwritten. The claims are grouped by claim number. The report can show both institutional and non- institutional claims. The fields displayed on the report are: Owner FI; Region; ICN; Claim Level User Defined Code; Solicited Indicator; Set Number; Duplicate Flag Value; Risk Indicator; Responsible FI; Sponsor *ID*; *Patient ID;* Patient Name; Provider *Number*; Provider Sub-ID; Amount Billed; Amount Paid; Government Paid Amount; Amount Identified For Recoupment; Amount Actually Recouped; Adjustment Amount.
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 Dupe Flag Indicator, Solicited Indicator, Exclude Base, PTC Dates, Care Dates, Set Level User Defined Codes, Claim Level User Defined Codes, Responsible FI, Region, Risk Indicator*, and Enrollment Codes*.
REPORT NOTES:	The data used by this report format is claim level data. For non-institutional claims, the billed, paid and net Government paid amounts are claim level not line-item level dollar amounts.

Status Code = All
Owner Type = All
Claim Type = All
Adjust Type = All
Match Type = All
Exclude Base Claims = No
Owner FI = All
Owner Region = All
Resp FI = All
Resp Region = All
Enroll Codes = All
Set Number = All
Dupe Flag = All
Solicited = All
Claim User Codes = All
Set User Codes = All
Risk Ind = All

Date: 4/29/05
Page 1

Risk Report By ICN

50 - Acme Claims Processing

Undetermined Region

ICN	USR CD	S ?	SET #	DUP FLG	RSK IND	RS FI	SPON ID	PATIENT ID	PATIENT NAME	PROVIDER NUMBER	PROV SUB-ID	AMT BILLED	AMT ALLOWED	GOV PAID	ID RECOUP	ACTUAL RECOUP	ADJ AMOUNT
19933335170207			22	Y	N	50	999999999	9999999990	SMITH,LESLIE,X	555555555	0000	$2,763.05	$1,115.44	$1,090.44	$1,000.00	$1,000.00	$1,115.44
19963024810904			76527		A	50	999999999	9999999990	SMITH,LESLIE,X	555555555	A004	$681.00	$177.34	$165.34	$0.00	$0.00	$0.00
19963123242029			76070		N	50	999999999	9999999990	SMITH,LESLIE,X	555555555	A001	$2,700.00	$1,005.60	$754.20	$0.00	$0.00	$0.00
19963240508876			77347		A	50	999999999	9999999990	SMITH,LESLIE,X	555555555	0000	$8,617.99	$3,478.39	$3,442.12	$0.00	$0.00	$0.00
									Region Totals				$5,776.77		$1,000.00		$1,115.44
												$14,762.04		$5,452.10		$1,000.00	
									Contractor Totals				$5,776.77		$1,000.00		$1,115.44
												$14,762.04		$5,452.10		$1,000.00	

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Status Code = All
Owner Type = All
Claim Type = All
Adjust Type = All
Match Type = All
Exclude Base Claims = No
Owner FI = All
Owner Region = All
Resp FI = All
Resp Region = All
Enroll Codes = All
Set Number = All
Dupe Flag = All
Solicited = All
Claim User Codes = All
Set User Codes = All
Risk Ind = All

Date: 4/29/05
Page 2

Risk Report By ICN

73 - HAL Systems Inc

Area 73A

ICN	USR CD	S ?	SET #	DUP FLG	RSK IND	RS FI	SPON ID	PATIENT ID	PATIENT NAME	PROVIDER NUMBER	PROV SUB-ID	AMT BILLED	AMT ALLOWED	GOV PAID	ID RECOUP	ACTUAL RECOUP	ADJ AMOUNT
19940474270059			3461	N	N	73	999999999	9999999990	SMITH,LESLIE,X	555555555	0000	$28,859.00	$28,859.00	$28,803.20	$0.00	$0.00	$0.00
19942844200023			3461		N	50	999999999	9999999990	SMITH,LESLIE,X	555555555	0000	$30,340.20	$12,295.96	$12,295.96	$0.00	$0.00	$0.00
19950334208001			3461		N	50	999999999	9999999990	SMITH,LESLIE,X	555555555	0000	$30,340.20	$12,295.96	$12,295.96	$0.00	$0.00	$0.00
									Region Totals				$53,450.92		$0.00		$0.00
												$89,539.40		$53,395.12		$0.00	
									Contractor Totals				$53,450.92		$0.00		$0.00
												$89,539.40		$53,395.12		$0.00	
									Report Totals				$59,227.69		$1,000.00		$1,115.44
												$104,301.44		$58,847.22		$1,000.00	

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REPORT CATEGORY:	Claim Report
REPORT MENU HIERARCHY AND FORMAT NAME:	REPORT ⇒CLAIM REPORTS ⇒RISK ⇒**RISK BY SET**
PRINTED REPORT TITLE:	Risk Report By Set Number
REPORT DESCRIPTION:	This report provides a listing of claims based on the Risk Indicator values selected by the user. The Risk Indicator identifies the claim as either financially underwritten or non-financially underwritten. The claims are grouped by set number. The report can show both institutional and non-institutional claims. The fields displayed on the report are: Owner FI; Region; Set Number; ICN; Claim Level User Defined Code; Solicited Indicator; Duplicate Flag Value; Risk Indicator; Responsible FI; Sponsor *ID*; *Patient ID;* Patient Name; Provider *Number*; Provider Sub-ID; Amount Billed; Amount *Allowed*; Government Paid Amount; Amount Identified For Recoupment; Amount Actually Recouped; Adjustment Amount.
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 Dupe Flag Indicator, Solicited Indicator, Exclude Base, PTC Dates, Care Dates, Set Level User Defined Codes, Claim Level User Defined Codes, Responsible FI, Region, Risk Indicator*, and Enrollment Codes*.
REPORT NOTES:	The data used by this report format is claim level data. For non-institutional claims, the billed, paid and net Government paid amounts are claim level not line-item level dollar amounts.

Status Code = All
Adjust Type = All
Owner Type = All
Exclude Base Claims = No
Claim Type = All
Match Type = All
Dupe Flag = All
Set Number = All
Owner FI = All
Resp Region = All
Owner Region = All
Resp FI = All
Solicited = All
Set User Codes = All
Claim User Codes = All
Risk Ind = All
Enroll Codes = All

Date: 4/29/05
Page 1

Risk Report By Set Number

50 - Acme Claims Processing

Undetermined Region

SET #	ICN	USR CD	S ?	DUP FLG	RSK IND	RS FI	SPON ID	PATIENT ID	PATIENT NAME	PROVIDER NUMBER	PROV SUB-ID	AMT BILLED	AMT ALLOWED	GOV PAID	ID RECOUP	ACTUAL RECOUP	ADJ AMOUNT
22	19933335170207			Y	N	50	999999999	9999999990	SMITH,LESLIE,X	555555555	0000	$2,763.05	$1,115.44	$1,090.44	$1,000.00	$1,000.00	$1,115.44
39	19942715160390				N	50	999999999	9999999990	SMITH,LESLIE,X	555555555	0001	$825.86	$226.30	$226.30	$0.00	$0.00	$0.00
									Region Totals				$1,341.74		$1,000.00		$1,115.44
												$3,588.91		$1,316.74		$1,000.00	
									Contractor Totals				$1,341.74		$1,000.00		$1,115.44
												$3,588.91		$1,316.74		$1,000.00	

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Status Code = All
Adjust Type = All
Owner Type = All
Exclude Base Claims = No
Claim Type = All
Match Type = All
Dupe Flag = All
Set Number = All
Owner FI = All
Resp Region = All
Owner Region = All
Resp FI = All
Solicited = All
Set User Codes = All
Claim User Codes = All
Risk Ind = All
Enroll Codes = All

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Risk Report By Set Number

99 - Inactive Contractor

Inactive-Area 20

SET #	ICN	USR CD	S ?	DUP FLG	RSK IND	RS FI	SPON ID	PATIENT ID	PATIENT NAME	PROVIDER NUMBER	PROV SUB-ID	AMT BILLED	AMT ALLOWED	GOV PAID	ID RECOUP	ACTUAL RECOUP	ADJ AMOUNT
22221	19951000627827			N	A	99	999999999	9999999990	SMITH,LESLIE,X	555555555	0000	$1,860.00	$1,090.56	$1,075.56	$0.00	$0.00	$0.00
									Region Totals			$1,860.00	$1,090.56	$1,075.56	$0.00	$0.00	$0.00

Inactive-Area 30

SET #	ICN	USR CD	S ?	DUP FLG	RSK IND	RS FI	SPON ID	PATIENT ID	PATIENT NAME	PROVIDER NUMBER	PROV SUB-ID	AMT BILLED	AMT ALLOWED	GOV PAID	ID RECOUP	ACTUAL RECOUP	ADJ AMOUNT
55	19932980656126			N	A	99	999999999	9999999990	SMITH,LESLIE,X	555555555	0002	$95,435.32	$201,551.67	$226.30	$0.00	$0.00	$0.00
									Region Totals			$95,435.32	$201,551.67	$226.30	$0.00	$0.00	$0.00
									Contractor Totals			$97,295.32	$202,642.22	$1,301.85	$0.00	$0.00	$0.00
									Report Totals			$100,884.23	$203,983.96	$2,618.59	$1,000.00	$1,000.00	$1,115.44

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REPORT CATEGORY:	Claim Report
REPORT MENU HIERARCHY AND FORMAT NAME:	REPORT ⇒CLAIM REPORTS ⇒RISK ⇒**RISK SUMMARY**
PRINTED REPORT TITLE:	Risk Summary Report
REPORT DESCRIPTION:	This report summarizes by Region the amounts billed, paid and Government paid amounts, as well as the amounts identified for recoupment, amounts actually recouped, and adjustment amounts. The fields displayed on the report are: *Owner FI;* Region; Amount Billed; Amount *Allowed*; Government Paid Amount; Amount Identified for Recoupment; Amount Actually Recouped; and Adjustment Amount.
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 Dupe Flag Indicator, Solicited Indicator, Exclude Base, PTC Dates, Care Dates, Set Level User Defined Codes, Claim Level User Defined Codes, Responsible FI, Region, Risk Indicator*, and Enrollment Code*.
REPORT NOTES:	The data used by this report format is claim level data. For non-institutional claims, the billed, paid and net Government paid amounts are claim level not line-item level dollar amounts.

Status Code = All
Adjust Type = All
Owner Type = All
Exclude Base Claims = No
Claim Type = All
Match Type = All
Dupe Flag = All
Set Number = All
Owner FI = All
Owner Region = All
Resp FI = All
Resp Region = All
Risk Ind = All
Solicited = All
Set User Codes = All
Claim User Codes = All
Enroll Codes = All

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Risk Summary Report

55 - East West Claims						
	Amt Billed	Amt Allowed	Govt Paid	ID Recoup	Actual Recoup	Adj Amt
Area 55	$12,120.92	$6,207.16	$6,157.16	$0.00	$0.00	$0.00
Contractor Totals	$12,120.92	$6,207.16	$6,157.16	$0.00	$0.00	$0.00

99 - Inactive Contractor						
	Amt Billed	Amt Allowed	Govt Paid	ID Recoup	Actual Recoup	Adj Amt
Inactive-Area 20	$3,505.00	$2,041.97	$2,026.97	$0.00	$0.00	$0.00
Inactive-Area 30	$721,760.08	$602,283.44	$602,283.44	$0.00	$0.00	$0.00
Contractor Totals	$725,265.08	$604,325.41	$604,310.41	$0.00	$0.00	$0.00
Grand Totals	$737,386.00	$610,532.57	$610,467.57	$0.00	$0.00	$0.00

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REPORT CATEGORY:	Claim Report
REPORT MENU HIERARCHY AND FORMAT NAME:	REPORT ⇒CLAIM REPORTS ⇒PROVIDER ⇒**CLAIM COUNTS**
PRINTED REPORT TITLE:	Provider Claim Count Report Grouped By Provider Number and Sub-ID
REPORT DESCRIPTION:	This report provides a total count by Provider Tax ID and Provider Sub-ID of all claims associated with selected providers. The fields displayed are: Provider Tax ID; Provider Sub-ID; and Total Number of Claims.
REPORT PARAMETER OPTIONS:	Users may customize the report by selecting: All "Standard" parameters minus Last (update) Date, Set Range (Claim Set Status; Adjustments, Set Owner Type; Claim Type, Match Type, Date Type, *Set Range,* FI, Region) plus Dupe Flag Indicator, PTC Dates, Responsible FI, Region, Provider Tax IDs*, and Enrollment Code*.
REPORT NOTES:	The data used by this report format is claim level data.

Status Code = All
Adjust Type = All
Owner Type = All
Claim Type = All
Match Type = All
SetNumFrame
Dupe Flag = All
Owner FI = All
Owner Region = All
Resp FI = All
Resp Region = All
Provider Tax Codes= All
Enroll Codes = All

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Provider Claim Count Report
Grouped by Provider Number and Sub ID

Tax ID : 555555555		#Claims
Sub ID: 0000		
	Sub Id Totals:	81
Sub ID: 0001		
	Sub Id Totals:	14
Sub ID: 0002		
	Sub Id Totals:	6
Sub ID: 0003		
	Sub Id Totals:	4
Sub ID: 0004		
	Sub Id Totals:	2
Sub ID: 0005		
	Sub Id Totals:	2
Sub ID: 0008		
	Sub Id Totals:	2
Sub ID:		
	Sub Id Totals:	7
	Tax Id Totals:	111

Tax ID :		#Claims
Sub ID:		
	Sub Id Totals:	107
	Tax Id Totals:	94

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REPORT CATEGORY:	Claim Report
REPORT MENU HIERARCHY AND FORMAT NAME:	REPORT ⇒CLAIM REPORTS ⇒PROVIDER ⇒**CLAIM DETAIL**
PRINTED REPORT TITLE:	Provider Claim Detail Report Grouped By Provider Number And Sub ID
REPORT DESCRIPTION:	This report provides a listing of claims grouped by Provider Tax ID and Sub-ID, associated with selected providers. The fields displayed are: Provider Tax ID; Provider Sub-ID; ICN; Time Stamp; Claim Level User Defined Code; Solicited Indicator; Set #; Duplicate Flag Indicator; Sponsor *ID*; *Patient ID;* Patient Name; Amount *Govt* Paid; PTC Date; Responsible FI; Total Number of Claims and Total Paid Amounts by Provider Sub-ID; and Total number of Claims and Total Paid Amounts by Provider Tax ID.
REPORT PARAMETER OPTIONS:	Users may customize the report by selecting: All "Standard" parameters minus Last (update) Dates (Owner Type, Claim Set Status; Adjustments, Claim Type, Match Type, Date Type, Set Range, FI, Region) plus Dupe Flag Indicator, Solicited Indicator, PTC Dates, Responsible FI, Region, Set Level User Defined Codes, Claim Level User Defined Codes, and Provider Tax IDs*, and Enrollment Codes*.
REPORT NOTES:	The data used by this report format is claim level data.

Status Code = All
Adjust Type = All
Claim Type = All
Owner Type = All
Match Type = All
Dupe Flag = All
Set Number = All
Owner FI = All
Owner Region = All
Resp FI = All
Resp Region = All
Provider Tax Codes = All
Solicited = All
Set User Codes = All
Claim User Codes = All
Enroll Codes = All

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Provider Claim Detail Report
Grouped by Provider Number and Sub ID

Prov Tax ID **555555555**

Sub ID **0008**

ICN	TIME	USER CODE	S ?	SET#	DUP FLG	SPON ID	PATIENT ID	PATIENT NAME	AMT GOVT PAID	PTC DATE	RESP FI
19941300621078	000000			63		999999999	9999999990	SMITH,LESLIE,X	$21,915.94	6/30/1994	50
19941360665510	000000			63	N	999999999	9999999990	SMITH,LESLIE,X	$21,915.94	6/10/1994	99
								#CLAIMS	TOTAL AMT PAID		
						SUB ID TOTALS		2	$43,831.85		

Sub ID

19940424543435	999999			35		999999999	9999999990	SMITH,LESLIE,X	$42,877.69	10/14/1994	50
19940424543435	999999			15		999999999	9999999990	SMITH,LESLIE,X	$8,353.93	10/14/1994	50
19940424543435	999999			26697		999999999	9999999990	SMITH,LESLIE,X	$4,322.84	7/18/1995	50
19940424543435	999999			74334		999999999	9999999990	SMITH,LESLIE,X	$2,042.84	11/12/1996	50
19940424543435	999999			66804		999999999	9999999990	SMITH,LESLIE,X	$5,721.12	8/28/1996	50
19940424543435	999999			71410		999999999	9999999990	SMITH,LESLIE,X	$1,658.54	10/16/1996	50
19940424543435	999999			74409		999999999	9999999990	SMITH,LESLIE,X	$1,045.74	11/08/1996	50
								#CLAIMS	TOTAL AMT PAID		
						SUB ID TOTALS		7	$66,022.70		
						TAX ID TOTALS		9	$109,854.55		

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REPORT CATEGORY:	Claim Report
REPORT MENU HIERARCHY AND FORMAT NAME:	REPORT ⇒CLAIM REPORTS ⇒PROVIDER ⇒**CPT-4**
PRINTED REPORT TITLE:	Provider CPT-4 Report Grouped By Provider Tax ID and Sub ID (CPT-4 Claim Level Match Types Only)
REPORT DESCRIPTION:	This report shows line items which appear on non-institutional **claims** which carry a CPT-4 match type ('C') at the claim level (see REPORT NOTES below). Due to the way the Duplicate Claims System assigns match types to claims and sets, this report must be used very carefully. Users have the option in this report of selecting actual duplicate claims only. The user may think that the report is showing only actual duplicate line items identified by the CPT-4 match type criteria. In fact, the report is showing the line-items of actual ('Y') non-institutional duplicate claims which have been assigned a match type of CPT-4 (see REPORT NOTES below). As a result, line items identified using the OTHER match type may appear on this report along with the line items identified under the CPT-4 criteria which caused the claim to be assigned the match type of CPT-4. This report will not show any line items identified under the EXACT or NEAR match criteria since line items identified using the EXACT and NEAR match would force the claim(s) to be assigned a higher level match type than CPT- 4. This report looks for only those actual duplicate non-institutional **claims** with a match type of CPT- 4 and then lists the line items on those claims. This report can be used by Program Integrity staff to obtain a listing of the claims carrying a match type of CPT-4 and their associated line items. Using the Provider Claim Count Report, users can identify the provider numbers associated with high volumes of non-institutional claims involving line items whose last two digits of the procedure code have been changed. Then using the Provider CPT-4 Report and entering those provider numbers identified, the user can generate a listing of the non-institutional claims with line item details associated with those provider numbers. The fields displayed on this report are: ICN; Time Stamp; Claim Level User Defined Code; Solicited Indicator; Set #; Duplicate Flag Indicator; Sponsor *ID*; *Patient ID;* Patient Name; Line Item Match Type; Line Item Number; CPT-4 Code; Amount Paid CPT-4; PTC Date; and Responsible FI. The report is grouped by Provider Number and Sub-ID and provides sub-totals for each provider Sub-ID and grand totals for each provider Tax-ID. The sub-totals and grand totals sum the number of line items and the total Paid dollars.

REPORT PARAMETER OPTIONS:	Users may customize the report by selecting: All "Standard" parameters minus Match Type, Claim Type, Last Dates, Set Range (Set Owner Type, Claim Set Status, Adjustments, Date Type, FI, Region) plus Dupe Flag Indicator, Solicited Indicator, PTC Dates, Responsible FI, Region, Set Level User Defined Codes, Claim Level User Defined Codes, and Provider Tax ID. Users may customize the report by selecting: All claims or actual duplicate claims only (to be counted as an actual duplicate claim, it must have a "Y" Duplicate Flag value and be in a *Pending*, *Validate*, or *Closed* set); status (All, *Open*, *Pending*, *Closed*, *Validate*); only sets that have adjustments associated with them; multi-FI sets, single FI sets, or both; **set** match type (All, Exact, Near, Date Overlap, CPT-4, Other); a single processed-to-completion date or a range of processed-to- completion dates; a single load date or a range of load dates; one or all FIs; one, several or all regions within selected FIs. Users may also select one, several or all Provider Tax ID numbers to be included in the report.
REPORT NOTES:	Match types are applied at the line-item, claim, and set levels based on a hierarchy. The most stringent match type applicable is assigned at each level. The hierarchy for institutional claims is as follows: Exact, Near, Date Overlap and Other. For non-institutional claims, the hierarchy is as follows: Exact, Near, CPT-4, and Other. For both claim types, Exact Match criteria is the most stringent with Near Match next. Other Match is the least stringent. When the Duplicate Claims System identifies non- institutional potential duplicates, it is doing so at a **line item** level. When a line item is identified as a potential duplicate, the system labels the **line item** with the Match Type used to identify it as a potential duplicate. If a non-institutional **claim** contains line items identified as potential duplicates using more than one match type criteria (one line item identified under Exact Match criteria and another line item under CPT-4 criteria), the system uses the match type hierarchy and labels the **claim** with the most stringent match type appearing on the line items. If the **set** contains **claims** labeled with different match types (one claim labeled 'Near' and another labeled 'CPT-4'), the system uses the match type hierarchy and labels the **set** with the most stringent match type appearing on the claims.

Status Code = All
Adjust Type = All
Owner Type = All
Dupe Flag = All
Match Type = All
Owner FI = All
Owner Region = All
Resp FI = All
Resp Region = All
Provider Tax Codes = All
Set User Codes = All
Solicited = All
Claim User Codes = All

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Provider CPT-4 Report
Grouped by Provider Tax ID and Sub ID
(CPT-4 Claim Level Match Types Only)

ICN	TIME	USER CODE	S ?	SET#	DUP FLG	PATIENT ID	PATIENT NAME	LI Match	LINE Item #	CPT-4 Code	AMT PAID CPT-4 CODE	PTC DATE	RESP FI
Tax ID:													
Sub ID:													
19941362501086	000000			226		9999999990	SMITH,LESLIE,X	C	1	90812	$90.00	10/13/1994	50
19942692501409	000000			226	N	9999999990	SMITH,LESLIE,X	C	1	90844	$80.11	10/09/1994	50
19941362501086	000000			227		9999999990	SMITH,LESLIE,X	C	2	90812	$90.00	10/13/1994	50
19942692501409	000000			227	N	9999999990	SMITH,LESLIE,X	C	2	90844	$80.11	10/09/1994	50
19940462508505	000000			251	N	9999999990	SMITH,LESLIE,X	C	4	99221	$90.70	3/10/1994	50
19942022508010	000000			251		9999999990	SMITH,LESLIE,X	C	4	99291	$150.00	8/04/1994	50
19941640617670	000000			4899	N	9999999990	SMITH,LESLIE,X	C	1	98330	$366.80	8/04/1994	50
19941640617670	000000			4899	N	9999999990	SMITH,LESLIE,X	C	2	98335	$133.00	8/04/1994	50
19942340621783	000000			4899		9999999990	SMITH,LESLIE,X	C	1	98310	$183.50	11/14/1994	99
19942340621783	000000			4899		9999999990	SMITH,LESLIE,X	C	2	98315	$133.00	11/14/1994	99

	#LINE ITEMS	TOTAL AMT PAID
SUB ID TOTALS	10	$1,397.22
TAX ID TOTALS	10	$1,397.22

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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; *Current* 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, Reason Codes*, and Base Claims*.
REPORT NOTES:	The data used by this report format is claim level data.

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Status Code = All
Owner Type = All
Claim Type = All
Adjust Type = All
Match Type = All
Owner FI = All
Owner Region = All
Resp FI = All
Resp Region = All
Include Base? = N
Set Number = All
Reason Codes = All

Reason Code Explanation Report
Individual Claims

50 - Acme Claims Processing

Undetermined Region

SET #	STATUS	CURRENT LOAD DATE	ICN	TIME	S?	RESP FI	PTC DATE	DUP FLG	RSN CODE	REASON CODE EXPLANATION
35	O	12/16/1996	19940424543435	999999		50	10/14/1994	Y	D900	This is to test the Reason Code Explanation

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REPORT CATEGORY:	Claim Report
REPORT MENU HIERARCHY AND FORMAT NAME:	REPORT ⇒CLAIM REPORTS ⇒**REASON CODE EXPLANATION ⇒ENTIRE SET**
PRINTED REPORT TITLE:	Reason Code Explanation Report Entire Set
REPORT DESCRIPTION:	This report provides a listing of the explanations associated with reason codes by set number. 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 explanations associated with the claims in a set. Individual claim data is grouped within their respective sets. The fields displayed on this report are: Owner FI; Region; Set Number; Set Status; *Current* 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, Reason Codes*, and PTC Date*.
REPORT NOTES:	The data used by this report format is claim level data.

Status Code = All
Owner Type = All
Claim Type = All
Adjust Type = All
Match Type = All
Owner FI = All
Owner Region = All
Resp FI = All
Resp Region = All
Reason Codes = All
Set Number = All

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Reason Code Explanation Report
Entire Set

50 - Acme Claims Processing

Undetermined Region

SET #	STATUS	CURRENT LOAD DATE
35	O	12/16/1996

ICN	TIME	S?	RESP FI	PTC DATE	DUPE FLAG	RSN CODE	REASON CODE
19940424543435	999999		50	10/14/1994	Y	D900	This is to test the Reason Code Explanation

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REPORT CATEGORY:	Claim Report
REPORT MENU HIERARCHY AND FORMAT NAME:	REPORT ⇒CLAIM REPORTS ⇒**ADJUSTMENTS**
PRINTED REPORT TITLE:	Claims With Associated Adjustments
REPORT DESCRIPTION:	This report provides a listing of claims, grouped in their respective sets, with any associated adjustment claims which have been submitted. Only sets which contain one or more claims that have associated adjustments will be listed. The fields displayed on the report are: *Owner FI; Region;* Set Number; ICN; Time Stamp; Dupe Flag Indicator; Reason Code; Responsible FI; Sponsor *ID*; *Patient ID;* Patient Name; Provider ID; Provider Sub-ID; Claim Level Paid; Line Item Number; Line Item Paid Amount; Adjustment Flag; Adjustment Line Item; and Adjustment Paid Amount.
REPORT PARAMETER OPTIONS:	Users may customize the report by selecting: All "Standard" parameters minus Adjustments (Claim Set Status, Set Owner Type, Claim Type, Match Type, Date Type, Set Range, FI, Region) plus PTC Dates, Responsible FI, Region, Claim Level User Defined Codes.
REPORT NOTES:	The data used by this report format is claim and line item level data.

Status Code = All
SetAdjustFrame
Owner Type = All
Claim Type = All
Match Type = All
Set Number = All
Owner FI = All
Owner Region = All
Resp FI = All
Resp Region = All
Claim User Codes = All

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Claims with Associated Adjustments

SET #	TED Icn	TED Time	DUP ?	RSN Code	Resp FI	Spon ID	Patient ID	Patient Name	Prov ID	Prov Sub Id	Government Paid Amt	Line Item	Govt PD Amt CPT4
50 - Acme Claims Processing													
15	19941882424012	000000	N	BASE	50	999999999	9999999990	SMITH,LESLIE,X	555555555	0000	431.50	0	0.00
									Adjust Flag	Adjust Line Item		Adjust Govt Paid Amount	
									N	0			-431.50
									N	0			328.17
15	19941882424012	000000			50	999999999	9999999990	SMITH,LESLIE,X	555555555		8353.00	0	0.00
									Adjust Flag	Adjust Line Item		Adjust Govt Paid Amount	
										0			328.17
15	19941882424013	000000			50	999999999	9999999990	SMITH,LESLIE,X	555555555	0000	350.00	0	0.00
22	19933335170207	000000	Y	D203	50	999999999	9999999990	SMITH,LESLIE,X	555555555	0000	1090.44	0	0.00
									Adjust Flag	Adjust Line Item		Adjust Govt Paid Amount	
									Y	0			-1115.44
22	19942575143500	000000	N	BASE	50	999999999	9999999990	SMITH,LESLIE,X	555555555	0000	1087.54	0	0.00
									Adjust Flag	Adjust Line Item		Adjust Govt Paid Amount	
										0			0.00
35	19940424543435	000000	N	BASE	50	999999999	9999999990	SMITH,LESLIE,X	555555555	0000	8574.15	0	0.00
									Adjust Flag	Adjust Line Item		Adjust Govt Paid Amount	
										0			-49102.03
										0			-1005.40

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REPORT CATEGORY:	Claim Report
REPORT MENU HIERARCHY AND FORMAT NAME:	REPORT ⇒CLAIMS ⇒WORK SHEETS ⇒**INSTITUTIONAL**
PRINTED REPORT TITLE:	Institutional Claims Worksheet
REPORT DESCRIPTION:	This report resembles the paper duplicate claims reports provided to contractors in the past. This report lists institutional claim sets 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 institutional claims. The fields displayed on the report are: Owner FI; Region; ICN; Set Level User Defined Code; Solicited Indicator; Set Number; PTC Date; Responsible FI; Sponsor *ID*; *Patient ID;* Patient Name; Provider *Nbr*; Provider Sub-ID; Diagnosis; DRG; Amount Billed; Amount *Allowed*; Government Paid Amount; Dupe Flag?; Reason Code; ID Recoupment 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 *Claim Set Status, Claims* (Claim Set Status, Set Owner Type, Claim Type, Match Type, Date Type, Set Range, FI, Region) plus PTC Dates; *Adjustments; Care Dates; Solicited Flag;* Responsible FI; and Region.
REPORT NOTES:	The data used by this report format is claim level data.

Adjust Type = All
Owner Type = All
Match Type = All
Solicited = All
Set Number = All
Owner FI = All
Owner Region = All
Resp FI = All
Resp Region = All

Date: 4/29/05
Page 1

Institutional Claims Worksheet

50 - Acme Claims Processing

Undetermined Region

ICN	USR CD	S ?	SET #	PTC DATE	RS FI	SPON ID	PATIENT ID	PATIENT NAME	PROVIDER NUMBER	PROV SUB-ID	DIAG	DRG	AMT BILLED	AMT ALLOWED	AMT GOVT PAID	DUPE? (Y/N)	RSN CD	RECOUP/ RFND AMT
19962924725072			77425	10/17/96	50	999999999	9999999990	SMITH,LESLIE,X	555555555	0000	4240	104	$57,297.50	$24,076.93	$24,076.93	------	------	------
19962924725072			77425	11/26/96	50	999999999	9999999990	SMITH,LESLIE,X	555555555	0000	4240	104	$60,264.50	$24,320.22	$24,184.42	------	------	------

55 - East West Claims

Area 55

ICN	USR CD	S ?	SET #	PTC DATE	RS FI	SPON ID	PATIENT ID	PATIENT NAME	PROVIDER NUMBER	PROV SUB-ID	DIAG	DRG	AMT BILLED	AMT ALLOWED	AMT GOVT PAID	DUPE? (Y/N)	RSN CD	RECOUP/ RFND AMT
19943551605817			10697	1/26/95	55	999999999	9999999990	SMITH,LESLIE,X	555555555	0000	8442	222	$6,060.46	$3,103.58	$3,078.58	------	------	------
19950241642021			10697	1/27/95	50	999999999	9999999990	SMITH,LESLIE,X	555555555	0000	8442	222	$6,060.46	$3,103.58	$3,078.58	------	------	------

99 - Inactive Contractor

Inactive-Area 30

ICN	USR CD	S ?	SET #	PTC DATE	RS FI	SPON ID	PATIENT ID	PATIENT NAME	PROVIDER NUMBER	PROV SUB-ID	DIAG	DRG	AMT BILLED	AMT ALLOWED	AMT GOVT PAID	DUPE? (Y/N)	RSN CD	RECOUP/ RFND AMT
19932980656126			55	1/11/94	99	999999999	9999999990	SMITH,LESLIE,X	555555555	0002	7470	000	$95,435.32	$201,551.67	$201,551.67	------	------	------
19942280665422			55	9/7/94	99	999999999	9999999990	SMITH,LESLIE,X	555555555	0002	7470	000	$313,162.38	$301,141.72	$301,141.72	------	------	------
19942490640195			55	9/12/94	99	999999999	9999999990	SMITH,LESLIE,X	555555555	0002	7470	000	$313,162.38	$99,590.05	$99,590.05	------	------	------

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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 *ID*; *Patient ID;* Patient Name; Provider *Number*; 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 PTC Dates, *Care Dates,* Responsible FI, and Region.
REPORT NOTES:	The data used by this report format is line item level data.

Adjust Type = All
Owner Type = All
Match Type = All
Solicited = All
Set Number = All
Owner FI = All
Owner Region = All
Resp FI = All
Resp Region = All

Date: 5/2/05
Page 1

Non-Institutional Claims Worksheet

50 - Acme Claims Processing

Undetermined Region

ICN	USR CD	S ?	SET #	RS FI	SPON ID	PATIENT ID	PATIENT NAME	PROVIDER NUMBER	PROV SUB-ID	DIAG	LI	CPT-4 CODE	AMT BILLED CPT-4 CD	GOVT PD CPT-4 CD	DUPE? (Y/N)	RSN CD	RECOUP/ RFND AMT
19953624101154			79860	50	999999999	9999999990	SMITH,LESLIE,X			78906	1	99214	$78.60		------	------	------
19953624101154			79860	50	999999999	9999999990	SMITH,LESLIE,X			78906	2	74000	$14.20		------	------	------
19962044104011			79862	50	999999999	9999999990	SMITH,LESLIE,X			5269	1	42100	$510.00	$81.28	------	------	------
19962494100571			79862	50	999999999	9999999990	SMITH,LESLIE,X			5269	1	42100	$300.00	$254.03	------	------	------
19962494100571			79862	50	999999999	9999999990	SMITH,LESLIE,X			5269	2	42100	$210.00	$81.28	------	------	------

99 - Inactive Contractor

Inactive-Area 20

ICN	USR CD	S ?	SET #	RS FI	SPON ID	PATIENT ID	PATIENT NAME	PROVIDER NUMBER	PROV SUB-ID	DIAG	LI	CPT-4 CODE	AMT BILLED CPT-4 CD	GOVT PD CPT-4 CD	DUPE? (Y/N)	RSN CD	RECOUP/ RFND AMT
19951000627827			22221	99	999999999	9999999990	SMITH,LESLIE,X			42490	1	99214	$70.00	$53.45	------	------	------
19951000627827			22221	99	999999999	9999999990	SMITH,LESLIE,X			42490	2	93000	$75.00	$31.32	------	------	------
19951000627827			22221	99	999999999	9999999990	SMITH,LESLIE,X			42490	3	93307	$400.00	$255.77	------	------	------
19951000627827			22221	99	999999999	9999999990	SMITH,LESLIE,X			42490	4	93320	$200.00	$134.97	------	------	------

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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.

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Claim Level User Defined Field Definitions

Owner FI	Contract #	Code	Description	Active ?
50	MDA90504C0050	B4	testing	Y
50	MDA90504C0050	B4	testing	Y

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REPORT CATEGORY:	Summary/Management
REPORT MENU HIERARCHY AND FORMAT NAME:	REPORT ⇒SUMMARY/MANAGEMENT REPORTS ⇒**INST BY DUPLICATE TYPE**
PRINTED REPORT TITLE:	Institutional Summary Report Potentials/Actuals/Non-Duplicates By Contractor (grouped by Region)
REPORT DESCRIPTION:	This summary/management report shows the total number of institutional potential duplicates, actual duplicates, non-duplicates, and those not yet worked by the contractor for the initial or current load date selected or load date range specified by the user. The report lists the number of claims and the amount paid by match type. The report also shows the number of actual duplicates, non-duplicates, and potential duplicate claims as a percentage of the total number of potential duplicates loaded. For this report, potential duplicates are the universe of all non-base claims. Actual duplicates are those claims with a "Y" dupe flag in *Pending*, *Validate,* or *Closed* status. Non-duplicates are those non-base claims with an "N" dupe flag in *Pending*, *Validate,* or *Closed* status. Potential duplicates not worked are non-base claims in *Open* status irrespective of any dupe flag value. The dollar totals on the report are for non- base claims only.
REPORT PARAMETER OPTIONS:	Users may customize the report by selecting: All "Standard" parameters minus Claim Set Status; Claim Types; Match Types; Last Dates; Set Range (Adjustments, Set Owner Type, Date Type, FI, Region) plus Responsible FI, and Region, and Risk Indicator.
REPORT NOTES:	The data used by this report format is claim level data. It should be noted that the total number of claims and percentages shown on this report may differ from that shown on the "Actual vs. Potential" graph report. Any discrepancy will be due to the fact that this report will count a claim more than once if it appears in two or more sets owned by the same region but which have different match types. The graph, alternatively, will not count a claim more than once if it appears in two or more sets owned by the same region.

Adjust Type = All
Owner Type = All
Owner FI = All
Owner Region = All
Resp FI = All
Resp Region = All
Risk Ind = All

Date: 5/20/05
Page 1

Institutional Summary Report
Potentials/Actuals/Non-Duplicates by FI/Contractor

Match Type	Number of Potential Dupes	Potential Dupes $	Number of Actual Dupes	Actual Dupes % of Potential	Actual Dupes Amount Paid Govt Contr	Number of Non-Dupe Claims	Non -Dupes % of Potential	Non Dupes Amount Paid Govt Contr	Number of Potential Not Worked Claims	Not Worked % of Potential	Potential Not Worked Amount Paid Govt Contr
50 - Acme Claims Processing											
Undetermined Region											
Date Overlap	27	$331,343.09	1	3.70%	$1,090.44	0	0.00%	$0.00	24	88.89%	$326,774.08
Exact	13	$78,437.14	0	0.00%	$0.00	0	0.00%	$0.00	13	100.00%	$78,437.14
Near	16	$130,078.81	0	0.00%	$0.00	0	0.00%	$0.00	14	87.50%	$121,374.88
Other	3	$9,895.12	0	0.00%	$0.00	0	0.00%	$0.00	2	66.67%	$2,635.22
Region Totals	59	$549,754.16	1		$1,090.44	0		$0.00	53		$529,221.32
Contractor Totals	59	$549,754.16	1		$1,090.44	0		$0.00	53		$529,221.32
55 - East West Claims											
Area 55											
Exact	1	$3,078.58	0	0.00%	$0.00	0	0.00%	$0.00	1	100.00%	$3,078.58
Region Totals	1	$3,078.58	0		$0.00	0		$0.00	1		$3,078.58
Contractor Totals	1	$3,078.58	0		$0.00	0		$0.00	1		$3,078.58
73 - HAL Systems Inc											
Area 73A											
Date Overlap	2	$24,591.92	0	0.00%	$0.00	0	0.00%	$0.00	2	100.00%	$24,591.92
Region Totals	2	$24,591.92	0		$0.00	0		$0.00	2		$24,591.92
Contractor Totals	2	$24,591.92	0		$0.00	0		$0.00	2		$24,591.92
Grand Totals	62	$24,591.92	1		$1,090.44	0		$0.00	56		$556,891.82

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REPORT CATEGORY:	Summary/Management
REPORT MENU HIERARCHY AND FORMAT NAME:	REPORT ⇒SUMMARY/MANAGEMENT REPORTS ⇒ **NONINST BY DUPLICATE TYPE**
PRINTED REPORT TITLE:	Non-Institutional Summary Report Potentials/Actuals/Non-Duplicate *by FI/*Contractor
REPORT DESCRIPTION:	This summary/management report shows the total number of non-institutional potential duplicates, actual duplicates, non-duplicates, and those not yet worked by the contractor for the initial or current load dates selected or load date range specified by the user. The report lists the number of claims and the allowed amounts paid by match type. The report also shows the number of actual duplicates, non-duplicates, and potential duplicate claims as a percentage of the total number of potential duplicates loaded. This report does not count unique claims but rather all non-base claims appearing in sets with a particular match type, i.e., the total number of non-base claims appearing in CPT-4, Exact, Near, and Other match type sets. Since a non-institutional **claim** may appear in more than one set, the counts of the **claims** appearing on this report may be inflated. The dollars shown on this report, however, will not be inflated since a line-item will never appear in more than one set. As a result, the dollars appearing on this report are the paid amounts for the line items appearing in the sets in which their host claim appears. While the host claim may be counted more than once, the dollar amounts associated with the line items will not be counted more than once. For this report, potential duplicates are the universe of all non-base claims. Actual duplicates are those claims with a "Y" dupe flag in *Pending*, *Validate,* or *Closed* status. Non-duplicates are those non-base claims with an "N" dupe flag in *Pending*, *Validate,* or *Closed* status. Potential duplicates not worked are non-base claims in *Open* status irrespective of any dupe flag value. The dollar totals on the report are for non-base claims only.
REPORT PARAMETER OPTIONS:	Users may customize the report by selecting: All "Standard" parameters minus Claim Set Status, Claim Types, Match Types, Last Dates, Set Range (Adjustments, Set Owner Type, Date Type, Region) plus Responsible FI, Region, and Risk Indicator.

REPORT NOTES:	The data used by this report format is claim level and line-item data. It should be noted that the total number of claims and percentages shown on this report may differ from that shown on the "Actual vs. Potential" graph report. Any discrepancy will be due to the fact that this report will count a claim more than once if it appears in two or more sets owned by the same region but which have different match types. The graph, alternatively, will not count a claim more than once if it appears in two or more sets owned by the same region.

Adjust Type = All
Owner Type = All
Owner FI = All
Owner Region = All
Resp FI = All
Resp Region = All
Risk Ind = All

Date: 5/20/05
Page 1

Non-Institutional Summary Report
Potentials/Actuals/Non-Duplicates by FI/Contractor

Match Type	Number of Potential Dupes	Potential Dupes $	Number of Actual Dupes	Actual Dupes % of Potential	Actual Dupes Amount Paid Govt Contr	Number of Non-Dupe Claims	Non -Dupes % of Potential	Non Dupes Amount Paid Govt Contr	Number of Potential Not Worked Claims	Not Worked % of Potential	Potential Not Worked Amount Paid Govt Contr
50 - Acme Claims Processing											
Undetermined Region											
Date Overlap	3	$963.00	0	0.1200%	$0.00	0	0.00%	$0.00	3	100.00%	$963.00
Exact	21	$6,278.51	0	0.00%	$0.00	0	0.00%	$0.00	21	100.00%	$6,153.43
Near	23	$13,874.63	0	0.00%	$0.00	0	0.00%	$0.00	23	100.00%	$13,874.63
Other	15	$21,843.67	0	0.00%	$0.00	0	0.00%	$0.00	15	100.00%	$21,843.67
Region Totals	62	$42,959.81	0		$0.00	0		$0.00	62		$42,834.73
Contractor Totals	62	$42,959.81	0		$0.00	0		$0.00	62		$42,834.73
99 - Inactive Contractor											
Inactive-Area 20											
Near	2	$4,560.31	0	0.00%	$0.00	0	0.00%	$0.00	2	100.00%	$4,560.31
Region Totals	2	$4,560.31	0		$0.00	0		$0.00	2		$4,560.31
Contractor Totals	2	$4,560.31	0		$0.00	0		$0.00	2		$4,560.31
Grand Totals	64	$47,520.12	1		$1,090.44	0		$0.00	64		$47,395.04

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REPORT CATEGORY:	Summary/Management Report
REPORT MENU HIERARCHY AND FORMAT NAME:	REPORT ⇒SUMMARY/MANAGEMENT REPORTS ⇒**SET AGING REPORT**
PRINTED REPORT TITLE:	Set Aging Report
REPORT DESCRIPTION:	This report provides the total number of sets in *Open*, *Pending*, *Validate*, and *Closed s*tatus grouped by region and either initial or current load date (depending on which is selected) as of the date the report is run. The report also shows the percentage each total represents of the total number of sets counted. The fields displayed on the report are: Owner FI; Region; Initial or Current Load Date; Number and Percentage of Open Sets; Number and Percentage of Pending Sets; Number and Percentage of Validate Sets; Number and Percentage of Closed Sets; and the Total Number of Sets. The report provides sub-totals for each contract region and grand totals for each contractor.
REPORT PARAMETER OPTIONS:	Users may customize the report by selecting: All "Standard" parameters minus Status, Last Dates, Set Range (Adjustments, Set Owner Type, Claim Type, Match Type, Date Type, FI, Region).
REPORT NOTES:	The data used by this report format is set level data.

Adjust Type = All
Owner Type = All
Claim Type = All
Match Type = All
Owner FI = All
Owner Region = All

Date: 5/20/05
Page 1

Set Aging Report

Contractor Name	Region	Current Load Dt	Open Sets	Open Sets%	Pending Sets	Pending Sets%	Validate Sets	Validate Sets%	Closed Sets	Closed Sets%	Total Sets
50 - Acme Claims Processing	Undetermined Region	09/1996	35	87.50	0	0.00	5	12.50	0	0.00	40
		10/1996	72	100.00	0	0.00	0	0.00	0	0.00	72
		11/1996	6	100.00	0	0.00	0	0.00	0	0.00	6
		12/1996	68	93.15	0	0.00	0	0.00	5	6.85	73
		01/1997	49	96.08	0	0.00	2	3.92	0	0.00	51
Region Total Sets			**230**		**0**		**7**		**5**		**242**
Region Avg %				**95.04**		**0.00**		**2.89**		**2.07**	
Contractor Total Sets			**230**		**0**		**7**		**5**		**242**
Contractor Avg %				**95.04**		**0.00**		**2.89**		**2.07**	
55 - East West Claims	Area 55	10/1996	2	100.00	0	0.00	0	0.00	0	0.00	2
Region Total Sets			**2**		**0**		**0**		**0**		**2**
Region Avg %				**100.00**		**0.00**		**0.00**		**0.00**	
Contractor Total Sets			**2**		**0**		**0**		**0**		**2**
Contractor Avg %				**100.00**		**0.00**		**0.00**		**0.00**	
73 - HAL Systems Inc	Area 73A	10/1996	3	100.00	0	0.00	0	0.00	0	0.00	3
Region Total Sets			**3**		**0**		**0**		**0**		**3**
Region Avg %				**100.00**		**0.00**		**0.00**		**0.00**	
Contractor Total Sets			**3**		**0**		**0**		**0**		**3**
Contractor Avg %				**100.00**		**0.00**		**0.00**		**0.00**	
99 - Inactive Contractor	Inactive-Area 20	12/1996	3	100.00	0	0.00	0	0.00	0	0.00	3
Region Total Sets			**3**		**0**		**0**		**0**		**3**
Region Avg %				**100.00**		**0.00**		**0.00**		**0.00**	
99 - Inactive Contractor	Inactive-Area 30	12/1996	3	100.00	0	0.00	0	0.00	0	0.00	3
Region Total Sets			**3**		**0**		**0**		**0**		**3**
Region Avg %				**100.00**		**0.00**		**0.00**		**0.00**	
Contractor Total Sets			**6**		**0**		**0**		**0**		**6**
Contractor Avg %				**100.00**		**0.00**		**0.00**		**0.00**	
Grand Total Sets			**241**		**0**		**7**		**5**		**253**
Grand Avg %				**95.26**		**0.00**		**2.77**		**1.98**	

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REPORT CATEGORY:	Summary/Management Report
REPORT MENU HIERARCHY AND FORMAT NAME:	REPORT ⇒SUMMARY/MANAGEMENT REPORTS ⇒**CLAIM AGING REPORT**
PRINTED REPORT TITLE:	Claim Aging Report
REPORT DESCRIPTION:	This report provides the total number of non-base claims in *Open s*tatus (Not Worked), the total number of actual duplicate claims ('Y' Duplicate Flag Value in *Pending*, *Validate,* and *Closed* status) and the total number of non-duplicate claims ('N' Duplicate Flag Value in *Pending*, *Validate,* and *Closed* status) as of the date the report is run. The report also provides the total paid amounts of the non-base claims in *Open s*tatus (Not Worked), the total amounts identified for recoupment and actually recouped of the actual duplicate claims, and the total paid amounts of the non-duplicate claims. The report shows claim counts but for non-institutional claims the paid amount totals are the sum of the line-item paid amounts in the system. The report is grouped by Initial or Current Load Date (depending on which is selected) and region and provides sub-totals by region and grand totals by contractor.
REPORT PARAMETER OPTIONS:	Users may customize the report by selecting: All "Standard" parameters minus Status; Last Dates; Set Range (Adjustments, Set Owner Type, Claim Type, Match Type, Date Type, FI, Region) plus Responsible FI and Region.
REPORT NOTES:	The data used by this report format is claim level data.

Adjust Type = All
Claim Type = All
Owner Type = All
Match Type = All
Owner FI = All
Owner Region = All
Resp FI = All
Resp Region = All

Date: 5/3/05
Page 1

Claim Aging Report

Load Date	Not Worked #Claims	Not Worked Allowed Amount	Actual Dupes #Claims	Actual Dupes ID Recoup	Actual Dupes Actual Recoup	Non-Dupes #Claims	Non Dupes Allowed Amount
50 - Acme Claims Processing							
<Unassigned Region>							
09/1996	0	$0.00	1	$1,000.00	$1,000.00	0	$0.00
12/1996	2	$99,997.86	0	0.00	$0.00	0	$0.00
01/1997	2	$335.31	0	0.00	$0.00	0	$0.00
Region Totals	4	$100,333.17	1	$1,000.00	$1,000.00	0	$0.00
Contractor Totals	4	$100,333.17	1	$1,000.00	$1,000.00	0	$0.00
Grand Totals	4	$100,333.17	1	$1,000.00	$1,000.00	0	$0.00

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REPORT CATEGORY:	Summary/Management Report
REPORT MENU HIERARCHY AND FORMAT NAME:	REPORT ⇒SUMMARY/MANAGEMENT REPORTS ⇒ **ARCHIVED SET REPORT**
PRINTED REPORT TITLE:	Archived Set Report
REPORT DESCRIPTION:	This report provides the total number of sets in the History Database in *Validate* and *Closed s*tatus grouped by region and Initial Load Date as of the date the report is run. While the report contains columns for *Open* status and *Pending* status, these will always be 0% since sets in *Open* and *Pending* status are never archived to the History Database. The report also shows the percentage each total represents of the total number of sets counted. The fields displayed on the report are: Owner FI; Region; Initial Load Date; Number and Percentage of Open Sets; Number and Percentage of Pending Sets; Number and Percentage of Validate Sets; Number and Percentage of Closed Sets; and the Total Number of Sets. The report provides sub-totals for each contract region and grand totals for each contractor.
REPORT PARAMETER OPTIONS:	Users may customize the report by selecting: All "Standard" parameters minus Status, Last Dates, Current Load Dates, Set Range (Adjustments, Set Owner Type, Claim Type, Match Type, Date Type, FI, Region).
REPORT NOTES:	The data used by this report format is set level data.

Adjust Type = All
Owner Type = All
Claim Type = All
Match Type = All
Owner FI = All
Owner Region = All

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Set Aging Report

Contractor Name	Region	Current Load Dt	Validate Sets	Validate Sets%	Closed Sets	Closed Sets%	Total Sets
22 - Excel Health Care	East Region	02/2005	0	0.00	1	100.00	1
Region Total			**0**	**0.00**	**1**	**100.00**	**1**
Contractor Total			**0**	**0.00**	**1**	**100.00**	**1**
23 - Seven Health Care	Undetermined Region	06/2004	0	0.00	1	100.00	1
		11/2004	0	0.00	2	100.00	2
		12/2004	0	0.00	1	100.00	1
Region Total			**0**	**0.00**	**4**	**100.00**	**4**
Contractor Total			**0**	**0.00**	**4**	**100.00**	**4**
Grand Total			**0**	**0.00**	**5**	**100.00**	**5**

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REPORT CATEGORY:	Summary/Management Report
REPORT MENU HIERARCHY AND FORMAT NAME:	REPORT ⇒SUMMARY/MANAGEMENT REPORTS ⇒**REASON CODE REPORT**
PRINTED REPORT TITLE:	Reason Code Report
REPORT DESCRIPTION:	This report provides a list of actual duplicate and non-duplicate reason codes and the total number claims to which each code was assigned. The report counts actual duplicate claims ('Y' Duplicate Flag value) and non-duplicate claims ('N' Duplicate Flag value) in *Pending*, *Validate,* and *Closed* sets.
REPORT PARAMETER OPTIONS:	Users may customize the report by selecting: All "Standard" parameters minus Claim Set Status (Adjustments, Set Owner Type, Claim Type, Match Type, Date Type, Set Range, FI, Region) plus Dupe Indicator, Solicited Indicator, Exclude Base, PTC Dates, Set Level User Defined Code, Claim Level User Defined Code, Responsible FI, Region, and Risk Indicator.
REPORT NOTES:	The data used by this report format is claim level data.

Adjust Type = All
Owner Type = All
Claim Type = All
Match Type = All
Dupe Flag = All
Owner FI = All
Owner Region = All
Resp FI = All
Resp Region = All
Set Number = All
Exclude Base Claims = No
Solicited = All
Set User Codes = All
Claim User Codes = All
Risk Ind = All

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Reason Code Report

Reason Code	Reason Code Description	Number of Claims
BASE	Initial submission	5
D203	Claims submitted by beneficiary and provider	1
	Total Claims	**6**

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REPORT CATEGORY:	Summary/Management Report
REPORT MENU HIERARCHY AND FORMAT NAME:	REPORT ⇒SUMMARY/MANAGEMENT REPORTS ⇒**REASON CODE BY INIT LOAD DATE**
PRINTED REPORT TITLE:	Reason Code Report by Initial Load Date
REPORT DESCRIPTION:	This report provides a list of actual duplicate and non-duplicate reason codes and the total number claims to which each code was assigned. The report counts actual duplicate claims ('Y' Duplicate Flag value) and non-duplicate claims ('N' Duplicate Flag value) in *Pending*, *Validate,* and *Closed* sets. The report is grouped by Initial Load Date.
REPORT PARAMETER OPTIONS:	This report provides a list of actual duplicate and non-duplicate reason codes and the total number claims to which each code was assigned. The report counts actual duplicate claims ('Y' Duplicate Flag value) and non-duplicate claims ('N' Duplicate Flag value) in *Pending*, *Validate,* and *Closed* sets. The report is grouped by Initial Load Date.
REPORT NOTES:	Users may customize the report by selecting: All "Standard" parameters minus Claim Set Status (Adjustments, Set Owner Type, Claim Type, Match Type, Date Type, Set Range, FI, Region) plus Dupe Flag Indicator, Solicited Indicator, Exclude Base, PTC Dates, Set and Claim Level User Defined Codes, Responsible FI, Region*, and Risk Indicator*.

Adjust Type = All
Owner Type = All
Exclude Base Claims = No
Claim Type = All
Match Type = All
Dupe Flag = All
Owner FI = All
Owner Region = All
Resp FI = All
Resp Region = All
Set Number = All
Solicited = All
Set User Codes = All
Claim User Codes = All
Risk Ind = All

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Page 1

Reason Code Report by Initial Load Date

Initial Load Date
09/1996

Reason Code		Number of Claims
BASE	Initial submission	5
D203	Claims submitted by beneficiary and provider	1
	Total	**6**
	Grand Total	**6**

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REPORT CATEGORY:	Summary/Management Report
REPORT MENU HIERARCHY AND FORMAT NAME:	REPORT ⇒SUMMARY/MANAGEMENT REPORTS ⇒**MODIFY FI**
PRINTED REPORT TITLE:	Changed Owner FI Sets
REPORT DESCRIPTION:	This report identifies multi-contractor sets which have had their ownership changed through the use of the "Modify FI" function on the system menu bar. It does not show multi-contractor sets which have had their ownership changed by the mass change process. The fields displayed on the report are: Set Number; Contractor; Changed Date; and User. The report shows each instance ownership of a multi-contractor set was changed; the name of the new owner contractor, the date ownership was changed, and the application User ID of the user who made the change. The first record listed for each set on the report shows the User as 'INITLOAD.' This means that the set was initially loaded by the system.
REPORT PARAMETER OPTIONS:	Users may customize the report by selecting: All "Standard" parameters minus Set Owner Type and Last Date (Claim Set Status Adjustments, Claim Type, Match Type, Date Type, Set Range, FI, Region) plus PTC Dates.
REPORT NOTES:	The data used by this report format is set level data. Single-line entries with "INITLOAD" as the user may appear on this report. These single-line entries will appear for sets where a user has begun the process of changing (modifying) ownership of the multi-contractor set, enters the reason for making the change, presses the **UPDATE CHANGES** button, but decides to "rollback" the changes, i.e., does not complete changing the set's ownership. Such sets will be listed on this report as a single-line entry with "INITLOAD" as the user.

Status Code = All
Adjust Type = All
Claim Type = All
Match Type = All
Set Number = All
Owner FI = All
Owner Region = All

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Changed Owner FI Sets

Set Number	FI/Contractor	Changed Date	User
33290		02/08/2005	INITLOAD
33290		02/08/2005	eidrhha
33290		02/09/2005	eidrhha
33290		03/21/2005	pprsqt01
33290		03/21/2005	pprsqt01
33290		03/24/2005	rajsinha
33290		03/24/2005	rajsinha
33290		03/24/2005	rajsinha
33290		03/24/2005	rajsinha
33290		03/24/2005	rajsinha
33290		03/24/2005	rajsinha
33290		03/24/2005	eidrhha
33290		03/25/2005	npinto
33504		02/08/2005	INITLOAD
33504		02/09/2005	eidrhha
33504		03/24/2005	rajsinha
33504		03/24/2005	rajsinha
33504		03/25/2005	npinto
33676		02/08/2005	INITLOAD
33676		03/22/2005	pprsqt01
33676		03/24/2005	rajsinha
33676		03/24/2005	rajsinha
33676		03/24/2005	rajsinha
33676		03/24/2005	rajsinha
33676		03/25/2005	npinto

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REPORT CATEGORY:	Summary/Management Report
REPORT MENU HIERARCHY AND FORMAT NAME:	REPORT ⇒SUMMARY/MANAGEMENT REPORTS ⇒**SET STATUS COUNT HISTORY**
PRINTED REPORT TITLE:	Set Status Count History
REPORT DESCRIPTION:	This report provides a count and percentage of sets within each status as of a date or range of dates grouped by contract.
REPORT PARAMETER OPTIONS:	Users may customize the report by selecting: *Owner* FI, Region, and As of Dates.
REPORT NOTES:	The data used by this report format is set level data.

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Owner FI = 66

Set Status Count History

Owner Region = All

As Of Date = All

East Region

East Region

ON	OPEN SETS	%	PENDING SETS	%	VALIDATE SETS	%	CLOSED SETS	%	TOTAL	%
02/03/2005	0	0.00%	2	100.00%	0	0.00%	0	0.00%	2	100.00%
02/04/2005	0	0.00%	2	100.00%	0	0.00%	0	0.00%	2	100.00%
02/11/2005	1	50.00%	1	50.00%	0	0.00%	0	0.00%	2	100.00%
02/12/2005	1	50.00%	1	50.00%	0	0.00%	0	0.00%	2	100.00%
02/16/2005	1	50.00%	1	50.00%	0	0.00%	0	0.00%	2	100.00%
02/17/2005	1	50.00%	1	50.00%	0	0.00%	0	0.00%	2	100.00%
02/17/2005	1	50.00%	1	50.00%	0	0.00%	0	0.00%	2	100.00%
02/18/2005	5	62.50%	3	37.50%	0	0.00%	0	0.00%	8	100.00%
02/18/2005	6	60.00%	4	40.00%	0	0.00%	0	0.00%	10	100.00%
02/18/2005	6	60.00%	4	40.00%	0	0.00%	0	0.00%	10	100.00%
02/19/2005	6	60.00%	4	40.00%	0	0.00%	0	0.00%	10	100.00%
03/24/2005	6	60.00%	4	40.00%	0	0.00%	0	0.00%	10	100.00%
04/01/2005	6	60.00%	4	40.00%	0	0.00%	0	0.00%	10	100.00%
04/04/2005	6	60.00%	4	40.00%	0	0.00%	0	0.00%	10	100.00%
04/05/2005	6	60.00%	4	40.00%	0	0.00%	0	0.00%	10	100.00%
04/07/2005	6	60.00%	4	40.00%	0	0.00%	0	0.00%	10	100.00%
04/15/2005	6	60.00%	4	40.00%	0	0.00%	0	0.00%	10	100.00%
04/18/2005	6	60.00%	4	40.00%	0	0.00%	0	0.00%	10	100.00%
04/18/2005	6	60.00%	4	40.00%	0	0.00%	0	0.00%	10	100.00%
04/19/2005	6	60.00%	4	40.00%	0	0.00%	0	0.00%	10	100.00%
04/20/2005	6	60.00%	4	40.00%	0	0.00%	0	0.00%	10	100.00%
04/24/2005	6	60.00%	4	40.00%	0	0.00%	0	0.00%	10	100.00%
04/25/2005	6	60.00%	4	40.00%	0	0.00%	0	0.00%	10	100.00%
04/26/2005	6	60.00%	4	40.00%	0	0.00%	0	0.00%	10	100.00%
04/27/2005	6	60.00%	4	40.00%	0	0.00%	0	0.00%	10	100.00%
04/28/2005	6	60.00%	4	40.00%	0	0.00%	0	0.00%	10	100.00%
04/29/2005	6	60.00%	4	40.00%	0	0.00%	0	0.00%	10	100.00%
05/01/2005	6	60.00%	4	40.00%	0	0.00%	0	0.00%	10	100.00%
05/02/2005	6	60.00%	4	40.00%	0	0.00%	0	0.00%	10	100.00%
05/03/2005	6	60.00%	4	40.00%	0	0.00%	0	0.00%	10	100.00%
05/04/2005	6	60.00%	4	40.00%	0	0.00%	0	0.00%	10	100.00%
05/05/2005	6	60.00%	4	40.00%	0	0.00%	0	0.00%	10	100.00%
05/06/2005	6	60.00%	4	40.00%	0	0.00%	0	0.00%	10	100.00%
05/07/2005	6	60.00%	4	40.00%	0	0.00%	0	0.00%	10	100.00%
05/09/2005	6	60.00%	4	40.00%	0	0.00%	0	0.00%	10	100.00%
05/10/2005	6	60.00%	4	40.00%	0	0.00%	0	0.00%	10	100.00%
05/11/2005	6	60.00%	4	40.00%	0	0.00%	0	0.00%	10	100.00%

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REPORT CATEGORY:	Summary/Management Report
REPORT MENU HIERARCHY AND FORMAT NAME:	REPORT ⇒SUMMARY/MANAGEMENT REPORTS ⇒ **PERFORMANCE STANDARD**
PRINTED REPORT TITLE:	Performance Standard
REPORT DESCRIPTION:	This report will be used to measure contractor compliance with the performance standard. The performance standard requires that no more than 10% of the sets remaining in *Open* status at the end of a month shall have load dates over 30 days old. The report shows the Reporting Month; Beginning Inventory; Receipts; Monthly Inventory; the total number of sets "Moved" during the reporting month; the total number of sets Moved within 30 days of set load dates; Ending Inventory; the total number of sets in Ending Inventory Over 30 Days old; the Percent Moved Within 30 Days; and the Percent Remaining Over 30 Days. The data is grouped by contract.

Field Descriptions

Field Name	Definition
Reporting Month:	The month and year for which the statistics are applicable.
Beginning Inventory:	The total number of sets in *Open* status at the beginning of the reporting month.
Receipts:	The total number of new sets loaded or the number of sets which changed to *Open* status during the reporting month.
Monthly Inventory:	The sum of the Beginning Inventory and Receipts.
Moved:	The total number of sets moved for *Open* status to *Pending*, *Validate*, or *Closed* status during the reporting month.
Moved Within 30 Days:	Of those sets moved during the reporting month, the number moved within 30 days of their load date.
Ending Inventory:	The Monthly Inventory minus the number Moved. The result is the total number of remaining sets in *Open* status.
Ending Inventory Over 30 Days:	The total number of claim sets remaining in *Open* status with load dates over 30 days old.
% Moved In 30 Days:	Of those sets moved, the percentage moved within 30 days of their load date.
% Remaining Over 30 Days:	The percentage of claim sets remaining in *Open* status with load dates over 30 days old.

REPORT PARAMETER OPTIONS:	Users may customize the report by selecting: a single reporting month or a range of reporting months; one or all FIs; one, several or all regions within selected FIs.
REPORT NOTES:	The data used by this report format is set level data.

MonthRange = All
Owner FI = 66
Owner Region = All

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Performance Standard

East Region

East Region

Reporting Month	Beginning Inventory	Receipts	Monthly Inventory	Moved	Moved Within 30 Days	Ending Inventory	Ending Inventory Over 30 Days	% Moved in 30 Days	% Remaining Over 30 Days
02/2005	0	0	0	0	0	6	1	0.00%	16.67%
03/2005	6	1	7	1	0	6	6	0.00%	100.00%
04/2005	6	0	6	0	0	6	6	0.00%	100.00%
05/2005	6	0	6	0	0	6	6	0.00%	100.00%

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REPORT CATEGORY:	Summary/Management Report
REPORT MENU HIERARCHY AND FORMAT NAME:	REPORT ⇒SUMMARY/MANAGEMENT REPORTS ⇒**DOLLAR TOTALS**
PRINTED REPORT TITLE:	Dollar Totals
REPORT DESCRIPTION:	This report summarizes the total dollars identified for recoupment and actually recouped, as well as the total paid amount of the applicable adjustments by Regional contract. The report reflects the total dollars on the system at the time the report is run. The fields displayed on the report are: Owner FI; Region; Total Amount Identified For Recoupment; Total Amount Actually Recouped; and the Total Paid Amount of the Associated Adjustments. The totals reflect only those sets in *Pending*, *Validate*, or *Closed* status.
REPORT PARAMETER OPTIONS:	Users may customize the report by selecting: All "Standard" parameters minus Claim Set Status (Adjustments, Set Owner Type, *Claim Type,* Match Type, Date Type, Set Range, FI, Region) plus Set Range, Set and Claim Level User Defined Codes, Responsible FI, Region*, and Enrollment Codes*.
REPORT NOTES:	The data used by this report format is set level data.

Adjust Type = All
Owner Type = All
Claim Type =All
Match Type = All
Set Number = All
Owner FI = All
Owner Region = All
Resp FI = All
Resp Region = All
Set User Codes = All
Claim User Codes = All
Enroll Codes = All

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Dollar Totals

50 - Acme Claims Processing

	Total Amount Identified For Recoupment	Total Amount Actually Recouped	Total Amount Identified for Recoupment
Undetermined Region	$1,000.00	$1,000.00	$1,000.00
Totals	$1,000.00	$1,000.00	$1,000.00

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REPORT CATEGORY:	Summary/Management Report
REPORT MENU HIERARCHY AND FORMAT NAME:	REPORT ⇒SUMMARY/MANAGEMENT REPORTS ⇒**LOAD DATE REPORT**
PRINTED REPORT TITLE:	Initial Load Date Report
REPORT DESCRIPTION:	This report provides a listing of set initial load dates grouped by contract.
REPORT PARAMETER OPTIONS:	Users may customize the report by selecting: All "Standard" parameters minus Set Range (Claim Set Status, Adjustments, Set Owner Type, Claim Type, Match Type, Date Type, FI, Region) *plus Enrollment Codes*.
REPORT NOTES:	The data used by this report format is set level data.

Status Code = All
Adjust Type = All
Owner Type = All
Match Type = All
Claim Type =All
Owner FI = All
Owner Region = All
Enroll Codes = All

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Initial Load Date Report

50 - Acme Claims Processing

Undetermined Region	Initial Load Date	Number Of Sets
	9/24/96	107
Totals by Region		107
Totals By Contractor		107

55 - East West Claims

Area 55	Initial Load Date	Number Of Sets
	9/24/96	1
Totals by Region		1
Totals By Contractor		1

73 - HAL Systems Inc

Area 73A	Initial Load Date	Number Of Sets
	9/24/96	1
Totals by Region		1
Totals By Contractor		1

99 - Inactive Contractor

Inactive-Area 20	Initial Load Date	Number Of Sets
	9/24/96	1
Totals by Region		1
Inactive-Area 30	**Initial Load Date**	**Number Of Sets**
	9/24/96	1
Totals by Region		1
Totals By Contractor		2
Grand Totals		111

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REPORT CATEGORY:	Summary/Management Report
REPORT MENU HIERARCHY AND FORMAT NAME:	REPORT ⇒SUMMARY/MANAGEMENT REPORTS ⇒**USER ACTIVITY DETAIL**
PRINTED REPORT TITLE:	User Activity Detail Report
REPORT DESCRIPTION:	This report provides a listing of transaction dates and times and associated User IDs grouped by set number. The report shows changes in Set Status; FI; User ID; Amount Identified For Recoupment; Amount Actually Recouped; and the Adjustment Amount.
REPORT PARAMETER OPTIONS:	Users may customize the report by selecting: Set Range, Transaction Dates, and User IDs.
REPORT NOTES:	The data used by this report format is set level data.

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User ID = eidrhha

Set Number = All

Transact Date = All

User Activity Detail Report

Set#	Stat	FI	Region	Init Load Date	Trans Date Time	User	ID'D Recoup Amt	Actual Recoup Amt	Adjusted Amount
3	O	65	MDA90603C0015	11/22/2004	11/22/04 11:00AM	CLAIMADD	$0.00	$0.00	$0.00
3	O	65	MDA90603C0015	11/22/2004	11/22/04 11:00AM	CLAIMADD	$0.00	$0.00	$0.00
3	C	65	MDA90603C0015	11/22/2004	1/25/05 11:45AM	eidrhha	$0.00	$0.00	$0.00
11166	O	65	MDA90603C0015	11/24/2004	1/12/05 12:02PM	eidrhha	$0.00	$0.00	($19.05)
11166	P	65	MDA90603C0015	11/24/2004	1/13/05 07:06AM	eidrhha	$19.05	$19.05	$11.05
11711	O	65	MDA90603C0015	11/24/2004	11/24/04 04:09PM	CLAIMADD	$0.00	$0.00	$0.00
11711	O	65	MDA90603C0015	11/24/2004	11/24/04 04:09PM	CLAIMADD	$0.00	$0.00	$0.00
11711	C	64	MDA90603C0011	11/24/2004	3/25/05 08:37AM	SYSTEM	$10.07	$10.07	$10.07
11711	O	64	MDA90603C0011	11/24/2004	3/25/05 08:39AM	SYSTEM	$0.00	$0.00	$0.00
11711	C	64	MDA90603C0011	11/24/2004	3/25/05 08:40AM	SYSTEM	$10.07	$10.07	$10.07
11711	V	64	MDA90603C0011	11/24/2004	3/25/05 08:44AM	SYSTEM	$10.07	$10.07	$10.07
11711	O	64	MDA90603C0011	11/24/2004	3/25/05 08:46AM	eidrhha	$0.00	$0.00	$0.00
11711	V	64	MDA90603C0011	11/24/2004	3/25/05 08:48AM	SYSTEM	$10.07	$10.07	$10.07
11711	V	64	MDA90603C0011	11/24/2004	3/25/05 08:49AM	eidrhha	$10.07	$10.07	$10.07
23741	C	64	MDA90603C0011	12/07/2004	2/3/05 08:31AM	jdoe	$45.56	$45.56	$45.56
23741	C	64	MDA90603C0011	12/07/2004	2/3/05 08:31AM	jdoe	$45.56	$45.56	$45.56
25471	V	65	MDA90603C0015	12/07/2004	3/22/05 07:22AM	eidrhha	$34.03	$8.00	($34.03)
25471	P	65	MDA90603C0015	12/07/2004	4/7/05 01:39PM	MARSHALL	$34.03	$8.00	$0.00
25668	O	65	MDA90603C0015	12/07/2004	12/7/04 010:27AM	CLAIMADD	$0.00	$0.00	$0.00
25668	O	65	MDA90603C0015	12/07/2004	12/7/04 10:27AM	CLAIMADD	$0.00	$0.00	$0.00
25668	p	65	MDA90603C0015	12/07/2004	12/28/04 10:44AM	eidrhha	$9.80	$5.00	$0.00
							$238.38	$181.52	$99.44

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REPORT CATEGORY:	Summary/Management Report
REPORT MENU HIERARCHY AND FORMAT NAME:	REPORT ⇒SUMMARY/MANAGEMENT REPORTS ⇒**USER ACTIVITY SUMMARY**
PRINTED REPORT TITLE:	User Activity Summary Report
REPORT DESCRIPTION:	This report provides a summary of the transactions performed by individual user ID. The report provides the total number of updates performed by a USER ID, the total number of sets updated by that USER ID, and the net change in status in the following categories: sets moved from *Open* to *Pending* and *Pending* to *Open*; *Open* to *Validate* and *Validate* to *Open*; *Open* to *Closed* and *Closed* to *Open*; *Pending* to *Closed* and *Closed* to *Pending*; *Pending* to *Validate* and *Validate* to *Pending*; and *Validate* to *Closed* and *Closed* to *Validate*. This report can provide management with a summary view of user activity by individual USER ID.
REPORT PARAMETER OPTIONS:	Users may customize the report by selecting: Set Range, Transaction Dates, and User IDs.
REPORT NOTES:	The data used by this report format is set level data.

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User ID = All

Transact Date = All

10000 >= Set Number <= 20000

USER ACTIVITY SUMMARY REPORT

			Net Change In Status From					
USER	**Total Updates**	**Sets Updated**	**O-P**	**O-V**	**O-C**	**P-C**	**P-V**	**V-C**
tmazzull	5	5	3	0	2	0	0	0
pprsqt01	2	2	2	0	0	0	0	0
eidrhha	35	13	1	3	-2	-1	1	2
pprsqt04	6	2	0	0	2	0	0	0
rparker	11	3	3	0	0	0	1	0
MARSHALL	1	1	0	0	0	0	0	0
pprsqt02	4	2	0	0	2	1	0	-1
fsyed	1	1	1	0	0	0	0	0
npinto	1	1	0	0	0	0	0	0
Totals	**66**	**30**	**10**	**3**	**4**	**0**	**2**	**1**

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REPORT CATEGORY:	Graphs
REPORT MENU HIERARCHY AND FORMAT NAME:	REPORT ⇒GRAPHS ⇒**ACTUAL VS. POTENTIAL**
PRINTED REPORT TITLE:	Total Actual Duplicates as a Percentage of Total Potential Duplicates
REPORT DESCRIPTION:	This report provides the user with a graph which shows the total number of distinct actual duplicate claims ('Y' Duplicate Flag values in *Pending*, *Validate*, or *Closed* status) as a percentage of the total number of distinct potential duplicates in the system (all non-base claims). The data displayed is grouped by region.
REPORT PARAMETER OPTIONS:	Users may customize the report by selecting: All "Standard" parameters minus Claim Set Status and Set Range (Adjustments, Set Owner Type, Claim Type, Match Type, Date Type, FI, Region).
REPORT NOTES:	The data used by this report format is set level data. If a claim appears in more than one set and the sets are owned by different regions, the claim will be counted once for each region.

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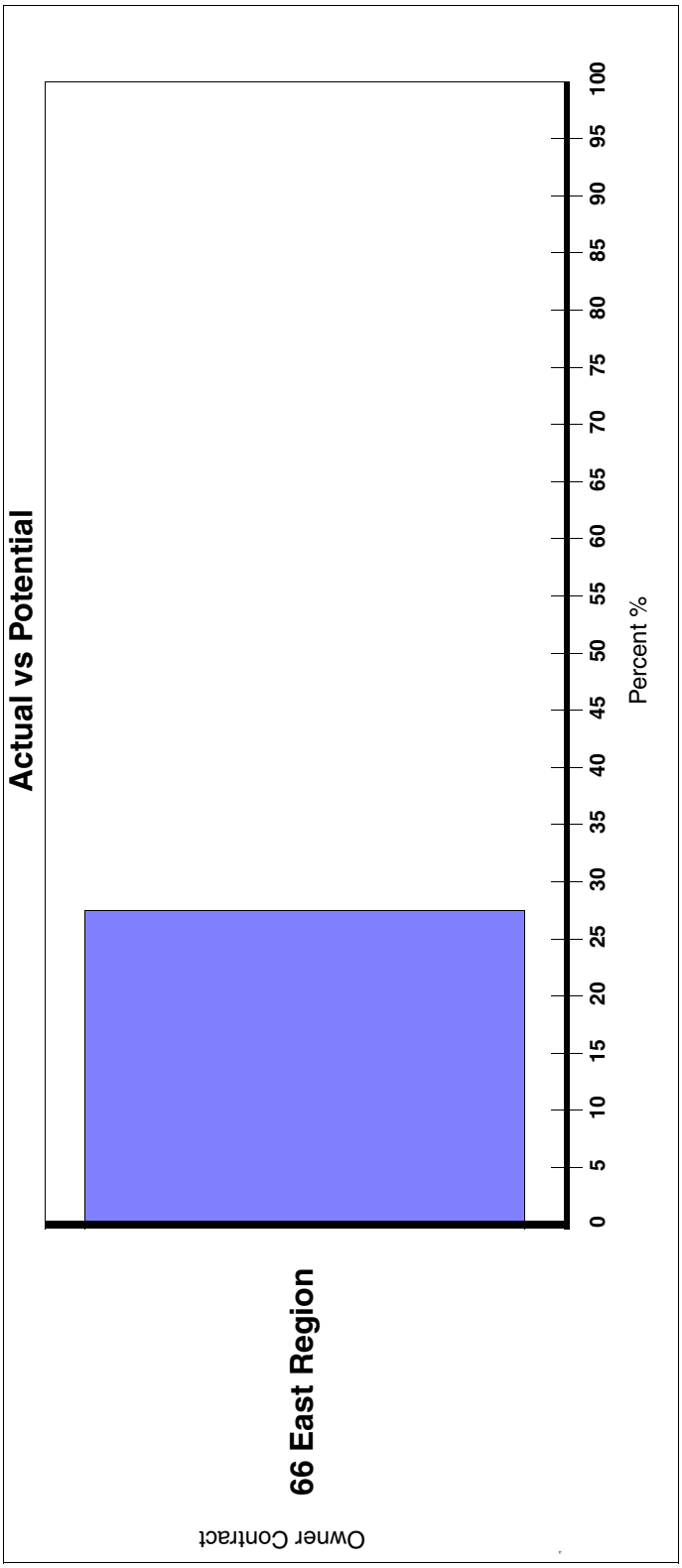
Adjust Type = All
Match Type = All
Owner Type = All
Claim Type =All
Owner FI = All
Owner Region = All

Total Actual Duplicates as a Percentage of Total Potential Duplicates



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REPORT CATEGORY:	Graphs
REPORT MENU HIERARCHY AND FORMAT NAME:	REPORT ⇒GRAPHS ⇒**USER ACTIVITY SUMMARY**
PRINTED REPORT TITLE:	User Activity Summary *Report*
REPORT DESCRIPTION:	This report provides the user with a graphical representation of the data in the User Activity Detail Report. The graph provides a summary of the transactions performed by individual user ID. The report provides the total number of updates performed by a USER ID, the total number of sets updated by that USER ID, and the net change in status in the following categories: sets moved from *Open* to *Pending* and *Pending* to *Open*; *Open* to *Validate* and *Validate* to *Open*; *Open* to *Closed* and *Closed* to *Open*; *Pending* to *Closed* and *Closed* to *Pending*; *Pending* to *Validate* and *Validate* to *Pending*; and *Validate* to *Closed* and *Closed* to *Validate*. This report can provide management with a summary view of user activity by individual USER ID.
REPORT PARAMETER OPTIONS:	Users may customize the report by selecting: Set Range, Transaction Dates, and User IDs.
REPORT NOTES:	The data used by this report format is set level data. This report is best viewed on screen or printed to a color printer.

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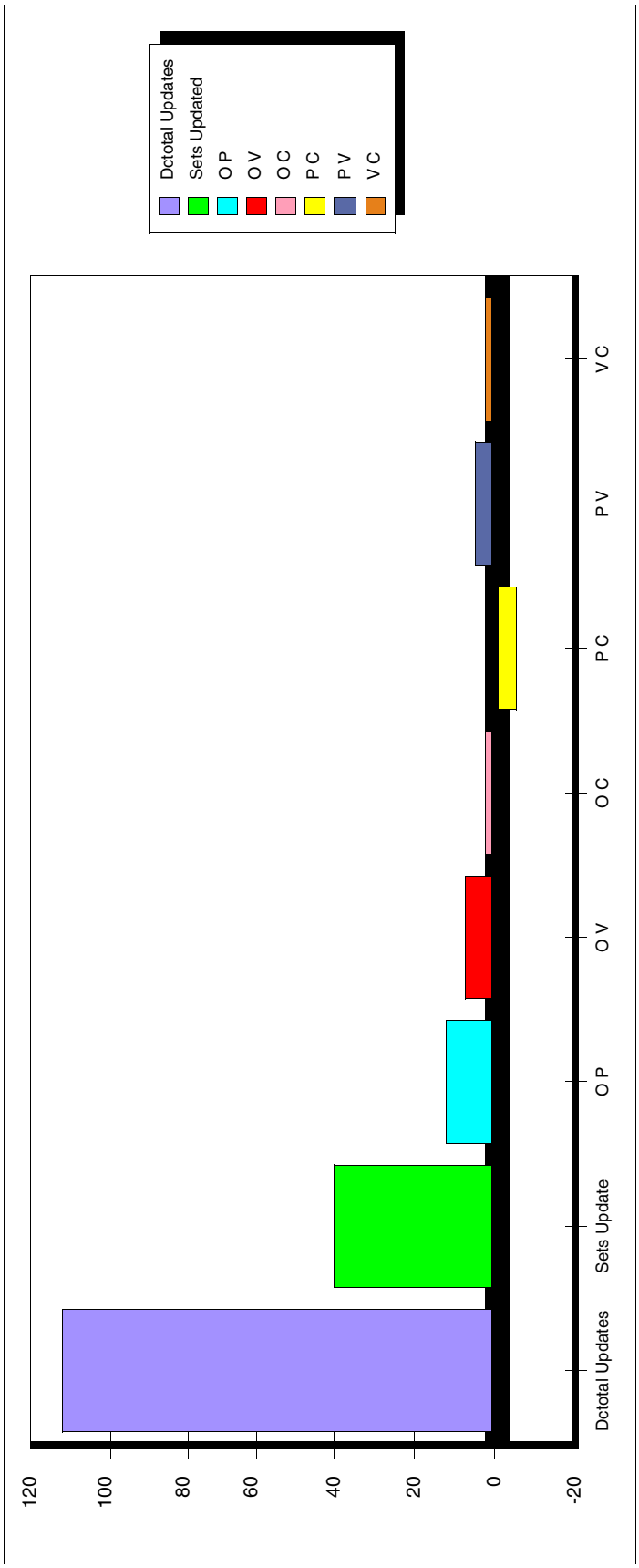
User ID = All

Set Number = All

Transact Date = All

USER ACTIVITY SUMMARY REPORT



USER ID : eidrhha

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DOWNLOAD FILES

DCSET.TXT *(SET LEVEL DATA)*	START	LENGTH	
Set Number	001	11	key
Record Type	012	1	
Set Status	013	1	
Set Match Type	014	1	
Multi-FI Ind	015	1	
Owner FI	016	2	
Contract Number	018	*13*	
Current Load Date	*031*	*10*	
Initial Load Date	*041*	*10*	
Last Update Date	*051*	*10*	
Amt Id Recoup	*061*	*14*	
Amt Actual Recoup	*075*	*14*	
Set Adjust Amt	*089*	*14*	
Adjust Ind	*103*	10	
User Id	*113*	8	
Set Level User Defined Code	*121*	2	
Provisional Acceptance Flag	*123*	*1*	

DCCLM.TXT *(CLAIM DETAIL)*	START	LENGTH	
Set Number	001	11	key
TED ICN	012	*17*	key
TED Time	*029*	6	key
Amount Billed Total	*035*	*14*	
Amount Allowed Total	*049*	*14*	
Amt Paid Govt Contrtr	*063*	*14*	
Sponsor ID	*077*	*9*	
Sponsor ID Type Code	*086*	*1*	
Patient Date of Birth	*087*	*10*	
Patient Name	*097*	*27*	
Patient Age	*124*	*6*	
DOD Patient ID	*130*	*10*	
Patient Zip/Country	*140*	*9*	
Patient Region Code	*149*	*2*	
Ptnt Catchment Area Ind	*151*	*1*	
Enrollment Code	*152*	*2*	
Prov Catchment Area Ind	*154*	*1*	

DCCLM.TXT *(CLAIM DETAIL)* (CONTINUED)	START	LENGTH
Multi Provider Id	*155*	*4*
Provider Zip/Country	*159*	*9*
Provider Region Code	*168*	*2*
Provider Tax Number	*170*	*9*
Provider Network Status Code	*179*	*1*
National Provider ID	*180*	*10*
Provider Group NPI	*190*	*10*
Special Rate Code	*200*	*2*
Special Processing Code 1	*202*	*2*
Special Processing Code 2	*204*	*2*
Special Processing Code 3	*206*	*2*
Special Processing Code 4	*208*	*2*
Type of Institution	*210*	*2*
Admit Date	*212*	*10*
Inst Care Begin Date	*222*	*10*
Inst Care End Date	*232*	*10*
Principal Diagnosis Cd	*242*	*6*
DRG Code	*248*	*3*
Discharge Status Code	*251*	*2*
Responsible FI	*253*	*2*
Processing FI	*255*	*2*
Resp. Contract Nbr	*257*	*13*
Proc. Contract Nbr	*270*	*13*
PTC Date	*283*	*10*
Cycle Number	*293*	*8*
Batch Sequence Nbr	*301*	*2*
Voucher Sequence Nbr	*303*	*2*
Bill Frequency Code	*305*	*1*
Mass Change Level	*306*	*6*
Risk Indicator	*312*	*1*
Claim Match Type	*313*	*1*
Claim Form Type	*314*	*1*
Dup Claim Indicator	*315*	*1*
Reason Code	*316*	*4*
Solicited Indicator	*320*	*1*
Claim Level User Defined Code	*321*	*2*
Claim Id Recoup	*323*	*14*
Claim Actual Recoup	*337*	*14*
Claim Adjustment Amount	*351*	*14*
Provisional Acceptance Flag	*365*	*1*
Multi Set Indicator	*366*	*1*

DCUTLADJ.TXT *(ADJUSTMENT)*	START	LENGTH	
Set Number	001	11	key
TED ICN	012	*17*	key
TED Time	*029*	6	key
Occurrence Count	*035*	6	key
Adjustment ID	*041*	*8*	*key*
Adjust Indicator	*049*	*1*	
Adjust Date	*050*	*10*	
CPT-4 Code	*060*	5	
Amt Allowed CPT-4 Code	*065*	*12*	
Non-Inst Care Begin Dt	*077*	*10*	
Responsible FI	*087*	2	
Cycle Number	*089*	*8*	
Provisional Acceptance Flag	*097*	*1*	

DCUTLZTN.TXT *(LINE ITEM)*	START	LENGTH	
Set Number	001	11	key
TED ICN	012	*17*	key
TED Time	*.029*	6	key
Occurrence Count	*035*	6	key
Line Item Dupe Indicator	*041*	*1*	
Line Item Match Type	*042*	*1*	
CPT-4 Code	*043*	*5*	
Place of Service	*048*	*2*	
Type of Service	*050*	*2*	
Non-Inst Care Begin Dt	*052*	*10*	
Non-Inst Care *End* Dt	*062*	*10*	
Amt Billed CPT-4 Code	*072*	*12*	
Amt Allowed CPT-4 Code	*084*	*12*	
Amount Paid Govt Contractor	*096*	*12*	
Line Item ID Recoup Amount	*108*	*12*	
Provider Number	*120*	*9*	
Provider Sub-ID	*129*	*4*	
National Provider ID	*133*	*10*	
Provider Group NPI	*143*	*10*	
Provider Zip Code	*153*	*9*	
Provider Specialty	*162*	*10*	
Provider Network Status Ind	*172*	*1*	
Enrollment Code	*173*	*2*	
Special Processing Code 1	*175*	*2*	
Special Processing Code 2	*177*	*2*	
Special Processing Code 3	*179*	*2*	
Special Processing Code 4	*181*	*2*	
Pricing Code	*183*	2	
CPT-4 Modifier 1	*185*	*2*	

DCUTLZTN.TXT *(LINE ITEM)* (CONTINUED)	START	LENGTH	
CPT-4 Modifier 2	*187*	*2*	
CPT-4 Modifier 3	*189*	*2*	
CPT-4 Modifier 4	*191*	*2*	
Provider Region Code	*193*	*2*	
Provider Catchment Area Ind	*195*	*1*	

DCSETCMT.TXT *(SET COMMENT)*	START	LENGTH	
Set Number	001	11	key
Comment Line Type	012	1	key
Comment Line Sequence #	013	6	key
Comment Line Text	019	255	

DCSETLOG.TXT *(SET TRANS LOG)*	START	LENGTH	
Set Number	001	11	key
Transaction Date	012	*26*	key
User I*D*	*038*	8	
Set Status	*046*	1	
Amt Id Recoup	*047*	*14*	
Amt Actual Recoup	*061*	*14*	
Owner FI	*075*	2	
Adjust Amt	*077*	*14*	
Contract Number	*091*	*13*	
Current Load Date	*104*	*10*	
Initial Load Date	*114*	*10*	

DCCMNT.TXT *(CLAIM COMMENT)*	START	LENGTH	
Set Number	001	11	key
TED ICN	012	*17*	key
TED Time	*029*	6	key
Comment Line Text	*035*	255	

*DC*SETUSR.TXT *(SET USER DEF CODES)*	START	LENGTH	
Owner FI	001	2	key
Contract Number	003	*13*	key
Set Level User Defined Code	*016*	2	key
User Defined Text	*018*	30	
Active/Inactive Indicator	*048*	1	

DCCLMUSR.TXT *(CLAIM USER DEF)*	START	LENGTH	
Owner FI	001	2	key
Contract Number	003	*13*	key
Claim Level User Defined Code	*016*	2	key
User Defined Text	*018*	30	
Active/Inactive Indicator	*048*	1	

DCCOUNT.TXT *(SET COUNTS)*	START	LENGTH	
As of Date	001	*26*	key
Owner FI	*027*	2	key
Contract Number	*029*	*13*	key
Open Status Number	*042*	11	
Pending Status Number	*053*	11	
Closed Status Number	*064*	11	
Validate Status Number	*075*	11	

DCCONTRACT.TXT *(CONTRACT)*	START	LENGTH	
Contractor Number	*001*	*13*	key
Contract Description	*014*	20	
FI Number	*034*	*2*	

DCFI.TXT *(CONTRACT)*	START	LENGTH	
FI/Contractor Number	001	2	key
Abbreviation	003	8	
FI/Contractor *Name*	011	60	

DCREASON.TXT *(REASON CODE)*	START	LENGTH	
Reason Code	*001*	4	key
Reason *Description*	*005*	60	
Explain Code	*065*	1	
Display Key	*066*	*1*	

DCENROLL.TXT (ENROLLMENT CODE)	*START*	*LENGTH*	
Enrollment Code	*001*	*2*	*key*
Enrollment Description	*003*	*40*	