
XPF – Provider Batch Import Subsystem

ErCcsRunXpf0

Facets Provider Import subsystem

- Batch-load process
- Facilitates the initial loading and subsequent
- Maintains data such as addresses, network affiliations, credentialing, etc
- The XP/F input data is for providers and in comma-delimited keyword format.

Special Features of XPF

- The strength of XP/F is the integration of incoming provider data with the data that already exists on the Facets database thereby reducing the possibility of creating erroneous data.
 - The Provider Reference Lookup table (CMC_PRXP_XREF) that support retention and look-up capability to synchronize the Provider key of the data source with the Facets Provider key.
 - The Find Provider capability assures non-duplication of rows on the Common Provider Indicative Information table (CMC_PRCP_COMM_PRAC) and potentially the Base Provider Table for Practitioner, Facility, Group and IPA table (CMC_PRPR_PROV) that exist prior to any import.

Highlights

- Update codes are available to apply any customer-directed instructions to direct the manner in which each input record will affect the Facets database.
- When a new date sensitive row (for example, NWPR) is created, the conversion can conditionally update the term date of a prior existing row.
- Three levels of edits ensure data integrity: Field level, Record level, and Relational.
 - Field Edit - On NWPR, the effective date is required and must be a valid date.
 - Record Edit - Also on NWPR, and on other date-sensitive rows, actual termination dates require a termination reason code.
 - Relational Edit - When creating a new credentialing row (PRCR), the provider ID must be valid. In other words, either a row must exist on the Facility Indicative Information Data table (CMC_PRFA_FACILITY or Common Provider Indicative Information table (CMC_PRCP_COMM_PRAC), either in the input data stream or on the database.

Highlights

- Data Synchronization: A table and appropriate indices support retention and lookup capability synchronizing the Provider key of the data source with the Facets Provider key.
- Find Provider capability is included, to assure non-duplication of rows on the Common Provider Indicative Information table (CMC_PRCP_COMM_PRAC) and potentially the Base Provider Table for Practitioner, Facility, Group and IPA (CMC_PRPR_PROV) that exist prior to any import.
- Each of the four valid Provider Entity Types (Practitioners, Facilities, Groups and IPAs) is processed in accordance with the special rules for each type.

Record Hierarchy

- There is a hierarchy for the records passed through XP/F, For example, Record Type PRPR should follow PRCP.
- A special record type, XPFH, is also required. Unique to the provider import process, XPFH represents the XP/Facets provider-level header data, and triggers the beginning of the data stream for each individual provider.
- Additionally, the Provider Reference Lookup table (CMC_PRXP_XREF) in the Provider data model is used to facilitate updates via a look-up of the Facets Provider key using the input source provider key (vendor data).

Update Codes

- IN Insert –
 - If the row is already there: Error
 - If the row is not there: Insert
- UP Update
 - If the row is already there: Update
 - If the row is not there: Error
- AP Apply
 - If the row is already there: Update
 - If the row is not there: Insert
 - **NOTE:** *The update code AP is not valid for the following record types: PRHI, PROF, PRPM, and PRSN.*

RECTYPE - XPFH

- The input data stream is processed one provider at a time. That is, the first input @pRECTYPE = XPFH begins an input data stream for one provider and ends with the last row immediately preceding the next input @pRECTYPE = XPFH.
- The XPFH record type contains a keyword of @pXPFH_UPDATE_CD (provider-level update code), which is the function that pertains to the entire provider data stream.
- Each of the other record types utilizes a record level update code that pertains to that record type only and overrides the XPFH update code for that individual record alone.
- XPFH is a mandatory and first Rec Type for each Provider data stream

Determining the Correct Facets Provider Key

- **Direct Mapping** - The Facets Provider key may be known to the vendor (or other source of the input), and may be passed accordingly via the XPFH header row PRPR_ID (or PRCP_ID, as appropriate to the update type).
- **Cross Referencing** - When the vendor does not know the Facets Provider key, the vendor's input key can be used for a lookup via the Provider Reference Lookup table (CMC_PRXP_XREF), matching the MCRE_ID and PRPR_MCPR_INPUT_ID to the XPFH.
- **Provider Matching** - When the vendor does not know the Facets Provider key and no matching CMC_PRXP_XREF row is found, the Find Provider subroutine is executed. If the provider is found, the system writes an appropriate CMC_PRXP_XREF row to facilitate future update activity.

Provider Cross Referencing

- The data source (for example, vendor or credentialing agency) can be expected to use its own established provider key structure, which is likely different from the Facets Provider key structure. Therefore, a mechanism is created to retain and cross-index the data source key within the Facets provider data model.
- XP/F includes a mechanism to accommodate the input data source's provider key and indexed for future look-ups whenever an update of that source data is run. Indexing off the vendor key field yields the Facets Provider key to permit an efficient update.
- The Provider Vendor Cross Reference table (CMC_PRXP_XREF) is used for this purpose. This table accommodates all columns necessary to identify a provider within its affiliation with the data source.

Find Provider Subroutine

- In order to maintain data integrity, it is critical to avoid duplicating provider data wherever possible. This is particularly true of practitioners, where the Facets data model calls for a one-to-many relationship between common practitioner and provider rows. Therefore, XP/F includes a Find Provider routine that incorporates a data-element-level match process.
- Find provider processing determines the Facets Provider key when processing a set of input rows for a provider and is executed if the PRPR_ID (or PRCP_ID) is not provided in the XPFH header row, or the CMC_PRXP_XREF alternate key index is unmatched.
- Search Hieracrchy
 - NPI – When NPI is present on the XPH record
 - SSN – When the parameter MatchPrcpSsn is Y
 - Tax ID – When MCTN ID is present.

Processing Match Criteria

- **MatchPrcpSsn** Enter a “Y” to use PRCP_SSN as a match criterion.
- **MatchPrprName** Enter a “Y” to use PRPR_NAME as a match criterion.
- **MatchMctnId** Enter a “Y” to use MCTN_ID as a match criterion.
- **MatchPradAddr1** Enter a “Y” to use PRAD_ADDR1 as a match criterion.
- **MatchPradCity** Enter a “Y” to use PRAD_CITY as a match criterion.
- **MatchPradState** Enter a “Y” to use PRAD_STATE as a match criterion.
- **MatchPradZip5Char** Enter a “Y” to use the first five characters of PRAD_ZIP as a match criterion.
- **MatchPradZip9Char** Enter a “Y” to use the first nine characters of PRAD_ZIP as a match criterion.
- **MatchPrrgTypeld** Enter a “Y” to use PRRG_TYPE and PRRG_ID as a match criterion.

Processing Match Criteria

- It is important to remember that all data element level matching occurs against the variables entered on the XPFH, not on the input PRPR or PRCP.
- When creating XPFH data, consider the intended run file switches. Run file settings are used to validate the presence of XPFH data, and an error will occur if a data element identified as a match criterion is missing
- Note - When the NPI keyword @pNPI is passed on XPFH, XPF automatically attempts to locate a provider with this NPI.

Processing Match Criteria

- If *one* exact match meets *all* criteria set in the run file switches (or multiple matches all contain the same PRCP_ID), the PRCP_ID is used for continued processing.
- If one exact match is *not* obtained, XP/F makes a final attempt to find a provider, matching on Last Name, First Name, Sex and Birth Date.
- If a match *occurs*, one of the following occurs:
 - **neither** the input nor the matched existing provider has a Social Security Number. This condition is acceptable, and processing can continue.
 - **either** the input or the matched existing provider has a Social Security Number. This condition is acceptable, and processing can continue.
 - **both** the input and the matched existing provider have Social Security Numbers. (If so, at this point in processing the numbers would be different.) This condition is not acceptable, and an error is generated.

Automatic Generation of Provider Id

- When a match can not be found using either the Provider Cross Reference Table or Find Provider and the data row will be inserted in the table, a 12 byte Facets PRPR_ID is required.
 - PRPR_IDs can be automatically generated through the run file using the following fields:
 - MCTN_ID
 - PRCP_SSN
 - NPI
 - Bytes 1 – 9 consist of a Root Value using one of the previous fields.
 - Bytes 10 – 12 are defined by the Root Value type.

Sample Input File – Practitioner

```
@pRECTYPE="XPFH",@pXPFH_UPDATE_CD="AP",@pXPFH_ENTITY_TYPE="P",
@pMCRE_ID="XPF_MCRE",@pXPFH_MCPR_INPUT_ID="TEN001",@pMCTN_ID="ETMM00000",@pPRCP_SSN="362536251",@pPRCP_LAST_NAME="PCMHC MK LAST1",@pPRCP_FIRST_NAME="Israel",@pPRCP_MID_INIT="I",@pPRCP_TITLE="M.D.",@pPRCP_BIRTH_DT="07/18/1964",@pPRCP_SEX="M",@pPRRG_TYPE="UP",@pPRAD_ADDR1="4321 SHORE FRONT AVE",@pPRAD_CITY="Brooklyn",@pPRAD_STATE="NY",@pPRAD_ZIP="11219",@pPRAD_ZIP_5CHAR="11219",@pPRAD_ZIP_9CHAR="112190000",@pPRCP_ID="TC362536251",@pPRPR_ID="PRPR480001"
@pRECTYPE="PRCP",@pPRCP_UPDATE_CD="AP",@pPRCP_SSN="362536201",
@pPRCP_LAST_NAME="PCMHC MK LAST1",@pPRCP_FIRST_NAME="Israel",@pPRCP_MID_INIT="I",@pPRCP_TITLE="M.D.",@pPRCP_SEX="M",@pPRCP_BIRTH_DT="07/18/1964",@pPRCP_MCCY_CTRY="USA",@pPRCP_MCTR_LANG="GERM",
@pPRCP_NPI="ETMNPI0000"
@pRECTYPE="PRPR",@pPRPR_UPDATE_CD="AP",@pPRPR_ENTITY="P",@pPRAD_TYPE_CHECK="P",@pPRPR_PAY_CL_IND="P",@pPRPR_MCTR_TYPE="MD",
@pPRPR_MCTR_PRTY="SOLE",@pPRCF_MCTR_SPEC="SURG",@pPRAD_TYPE_PRIM="P",@pPRAD_TYPE_MAIL="P",@pMCTN_ID="XPFCMCNT01",@pPRPR_STS="PA",@pPRPR_MCTR_REV="MALP",@pPRPR_PREAUTH_IND="N",@pPRPR_PA_Y_HOLD_DT="01/01/2000",@pPRPR_MCTR_LANG="ENGL",@pPR_EXTN_ADDR_IND="N" @RECTYPE="LEOF"
```

Run File Settings

- **NoUpdate=“Y”** Used for testing purposes, input will be edited and an error report generated but the input will not be committed to the database.
- **DebugDisplay=“Y”** Set this option to “Y” to see provider search results.
- Match Criteria for Find Provider:
 - MatchPrcpLastName=“Y”
 - MatchPrcpFirstName=“Y”
 - MatchPrcpBirthDt=“Y”
 - MatchPrcpSex=“Y”
 - MatchPrcpSsn=“Y” (recommended)
 - There is no match switch on the run file for NPI.

Run File Settings

- **XXXXReplace = 'Y'** Where XXXX = “*table_name*”, permits replacement of tables
- Used occasionally when database needs correction
- **VendorDataRequired** Looks for the presence of MCRE_ID and XPFH_MCPR_INPUT_ID in the XPFH row.
- These are required for Provider Cross Reference processing.
- **PrprIdRequired** Enter a “Y” to generate an error if the PRPR_ID is not specified in the header.

Run File Settings

- PRPR_ID Generation Options
- **<Item name =“Root”>MCTN_ID</Item>** Valid values are “MCTN_ID”, “PRCP_SSN”, or “NPI”
- Comprises the first 9 bytes of PRPR_ID
- **<Item name =“ SortSeq”>AN</Item>** Valid values are “A”, “N”, “AN”, or “NA”
- **<Item name =“Pos10Value”>-</Item>** Any character can be defined for the 10th byte
- If not defined, then it will be incremented like 11 and 12
- When NPI is selected as the root, bytes 11 and 12 are generated sequentially. The position 10 option is disabled.

Run File Settings

- **InputFile** Defines the location of the input file
- **ResubFile** Defines the location of the Resubmission file
- **InitialLoad** For an initial load to the database only
 - XPFH_UPDATE_CD is treated as IN
 - Does not look for existing rows on the database
- **NumberOfEnginesXpf** Enter the number of XPF0 processes that will be started simultaneously in a multi-engine job.
- **DeadlockRetryAttempts** Specify the desired number of retries to be attempted for a deadlocked transaction.
- **DeadlockWaitSeconds** Specify the number of seconds to wait between retry attempts. The procedure book default is 5 milliseconds.

Questions

Thank You



Facets Insights

April 2020

Agenda

- ✓ Facets Insights Basics
- ✓ Facets Insights Processing
- ✓ Facets Insights Batch
- ✓ Facets Insights Processes
- ✓ Facets Insights Dashboard
- ✓ IoT Messages

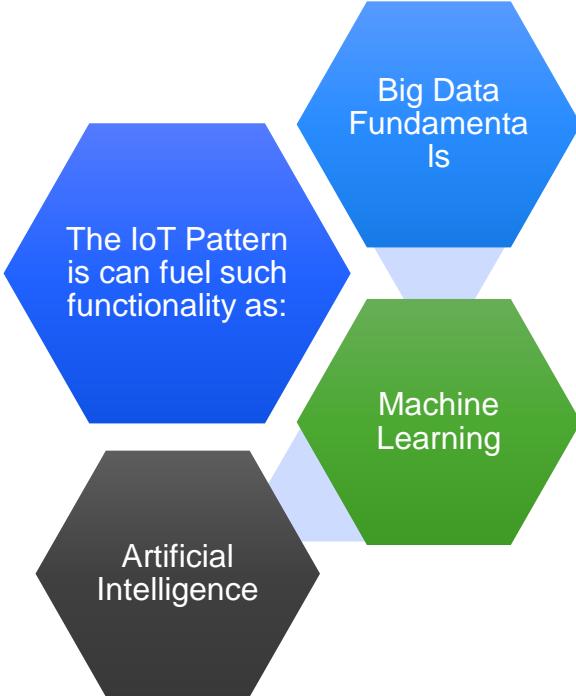
Facets Insights Basics

Elements to CORE Facets

Facets Insights (Optional) is an exciting new component that introduces the following elements into the core of Facets

Fundamental	Description
Machine Learning	Analytical models that can evaluate data from one to many sources and offer the probability of an outcome given that data set
Artificial Intelligence	The concept of machines performing tasks in a way that we would consider “smart.”
IoT Pattern	A pattern of computing, stating that systems provide telemetry describing their processing and processing environment. This telemetry is subsequently evaluated for patterns as part of machine learning models.
Closed Loop Processing	A pattern where the state of a given process is evaluated and an action may be taken. This evaluation can be manual or automated.
Big Data	A principle of computing where very large data sets are collected and analyzed.

IoT Patterns



Facets Insights Capability

Using the IoT pattern, Facets Insights provides the capability for Facets customers to:

Better understand the performance and utilization characteristics of Facets in various contexts including:

User actions and behaviors

Transactional processing via all channels

Components at various levels of granularity

Inject machine learning and artificial intelligence into Facets transactional processing thereby influencing transactions

Identify patterns of behavior within Facets entities and label those entities allowing those labels to be used as:

Qualifiers for other Facets components such as Facets Workflow or Facets Integrated Pricer

Data elements for further analysis

Features for additional machine learning models

Services API



Clients who install and configure Facets Insights can access the Services API option.

A major part of Facets Open Access is the Facets Web Services Library which offers customers a wide variety of service APIs that provide access to Facets data and functionality.

The Services API component of Facets Insights provides visibility into the performance and utilization characteristics of the Facets Web Services Library

Infrastructure

Facets Database Platform

Facets Insights Database (optional)

Facets Insights can be used in Facets that runs on any of the three Facets-supported platforms: Microsoft SQL server; Oracle; SAP (Sybase)

The Facets Insights database is delivered on Microsoft SQL server only.

The Facets Insights database is required only if a customer plans to leverage the functionality of Facets Insights.

The installation and upgrade of the Facets Insights database are controlled via the TriZetto Upgrade Framework in the same manner as the installation and upgrade for the Facets databases.

Prerequisites

Lists the software required to run Facets Insights.

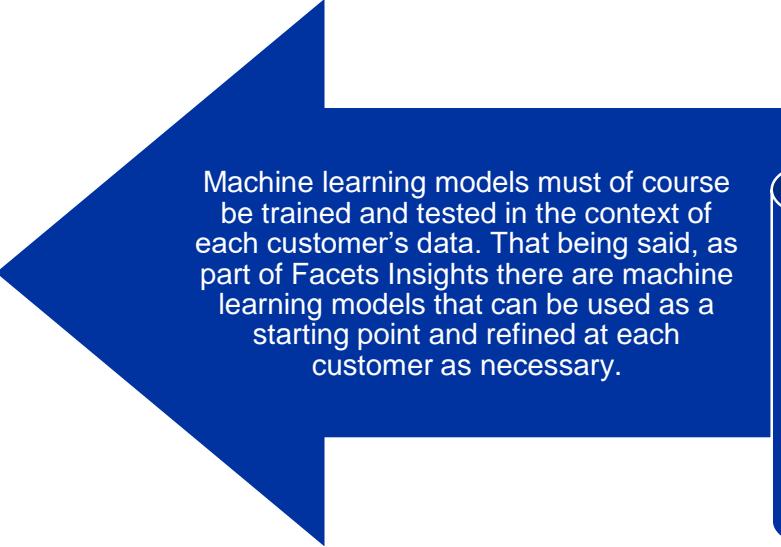
- .Net Core
 - .Net Core can be downloaded from Microsoft.
- Apache Kafka
 - Facets Insights also requires the Facets IoT Kafka topic to be configured.
- Other Third Party Products
 - Facets Insights leverages the following third party software products, which customers must acquire and install
 - Anaconda 5.10 (32 bit)
 - The Anaconda installation includes Python v3.6 which Facets Insights requires. It installs all core packages needed by any machine learning related code except the packages below which need to be installed independently
 - PyStan 2.17.1.0
 - Prophet v0.3

Please check the Compatibility Matrix for the version of the required third party software.

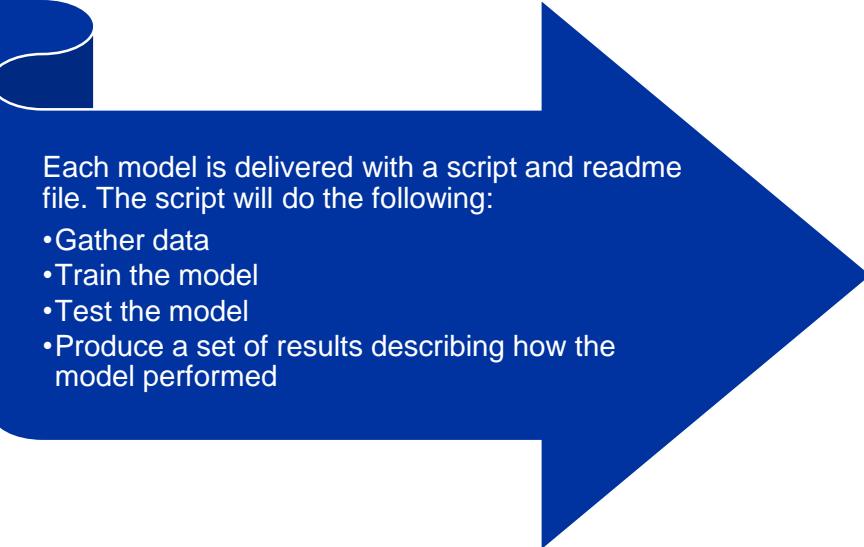
Installation - Application Server Software

Item	Description
Facets Insights Dashboard	This is an Angular application that is installed in the Facets Application website. The default location is: ...\\system\\inetpub\\wwwroot\\FacetsApplications\\INST In IIS there is a Facets Applications site with a subdirectory of INST
Facets Insights Services	These are ReST services that support the Facets Insights Dashboard. The default location is: ...\\system\\inetpub\\wwwroot\\FacetsApplications\\FacetsServices\\InsightsServices in IIS under site FacetsServices\\InsightsServices
Facets Insights Agent	This will be installed as a Windows Service

Models on the Shelf



Machine learning models must of course be trained and tested in the context of each customer's data. That being said, as part of Facets Insights there are machine learning models that can be used as a starting point and refined at each customer as necessary.



Each model is delivered with a script and readme file. The script will do the following:

- Gather data
- Train the model
- Test the model
- Produce a set of results describing how the model performed

Models on the Shelf Contd..

Model	Description
Member Retention	Use the Member Retention model to train a model that can predict how likely a member is to leave a plan within three months. This model is trained on historic Facets data using members that existed in a time frame you select.
Claim Adjustment	Use the Claim Adjustment model to train a model that can predict how likely a claim is to be adjusted. This model is trained on historic Facets data using claims that were created in a time frame you select.
Hospital Readmission	Use this model to predict how likely a member is to be readmitted to a hospital within three months of the current day. This model is trained on features from data in the Facets database using claims that fall within a time frame you select.

Configuration

Region Manager

- The Facets Region Manager is used to configure Facets Insights.

IoT Kafka Topic

- Facets Insights also requires the Facets IoT Kafka topic to be configured.

ReST Services

- Facets Services Server section

Facets Insights Agent

- The FacestInsightsAgent.exe executable is an **Edge** program. It reads the Facets messages from the Facets Kafka stream and writes a subset of them into the Facets Insights database.
C:> FacetsInsightsAgent.exe -h

Configuration Options

This application requires a Facets Region and a Basic authentication (Web basic Authentication) which is an encoded username and password. The application is defaulted to run as a registered Windows service.

Plug-ins

- Agent Plug-Ins provide specific processing against IoT messages written to Kafka. The Insights Agent reads the active Plug-ins from the Facets Region file.

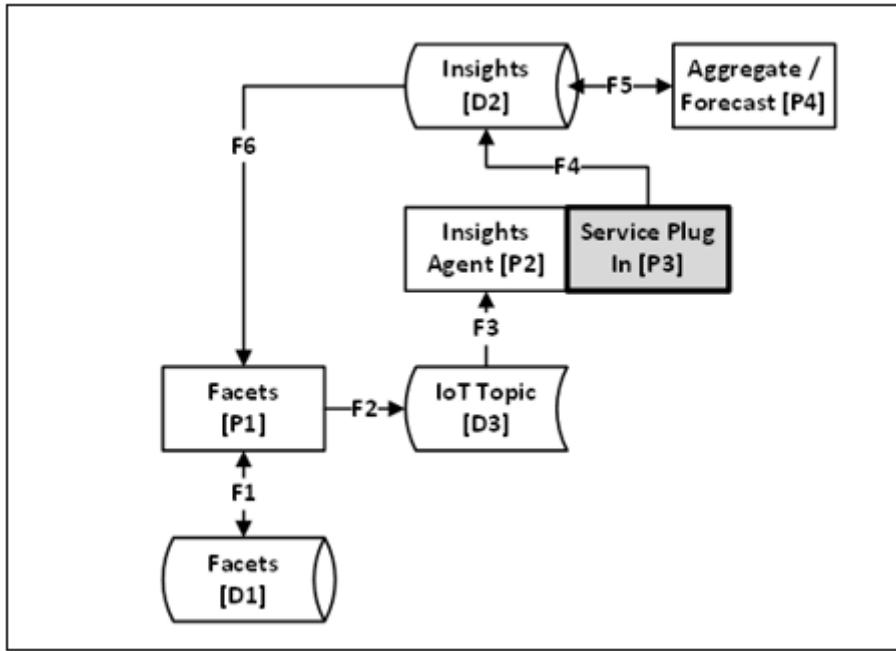
Console Mode

- Running the application in console mode allows you to review configuration and validate that they work in your environment.
- We highly recommend that you validate that the application is working as expected before registering as a service.
- In order to run as console application, you must always provide a valued --Region=Aaa entry.
- There are 2 other options you can use in console mode helpful in validating configuration and behavior.
- The first is the --Config option, this will display the complete evaluated configuration and display the values. Much of the configuration is drawn from the Facets Region file and other one is -h.

C:>FacetsInsightsAgent.exe --Region=fdfmfacfinarchdev --Config

Facets Insights Processing

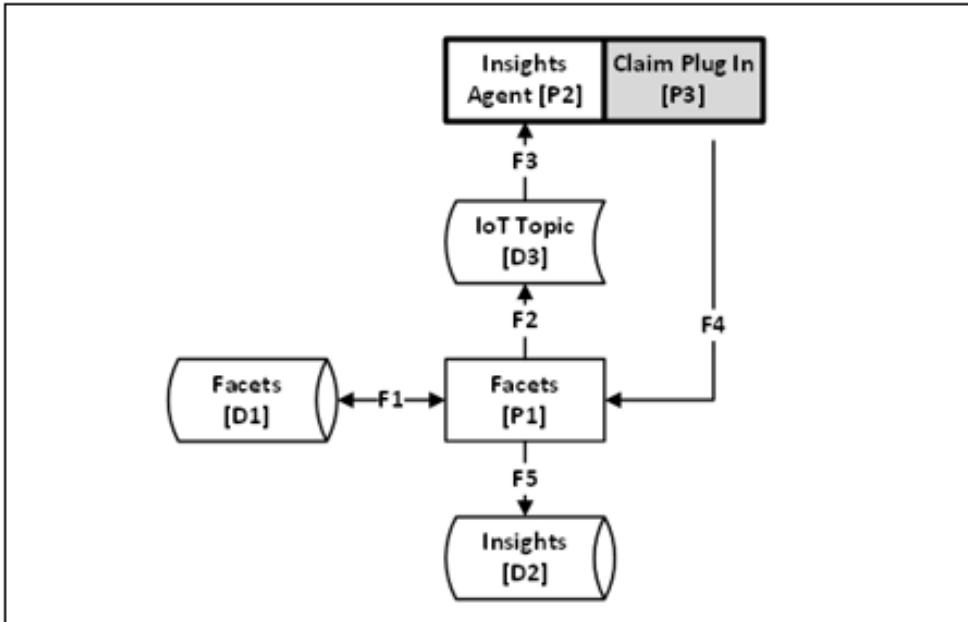
Services API Flow



Services API Flow Contd..

Item	Description
Facets [D1]	Facets transaction database
Insights [D2]	Facets Insights database
IoT Topic [D3]	Facets IoT Kafka topic
Facets [P1]	Facets transaction engine consisting of: <ul style="list-style-type: none">· Online Facets (also called Facets Interactive)· Facets Batch· Facets Open Access Services· TriZetto HIPAA Gateway responsible for processing transactions through all the channels in the list above.
Insights Agent [P2]	Facets Insights Agent responsible for consuming IoT data emitted by Facets brokering the messages to 1:n plug ins
Services Plug In [P3]	The services plug in is part of the Facets Insights Agent. It is responsible for: <ul style="list-style-type: none">· Writing data to the Facets Insights Database for the services transactions
Aggregate / Forecast [P4]	Facets Insights process responsible for creating aggregations and forecasts from the IoT data
Dataflow[F1]	Facets data used to process business transactions read from and updated to the Facets database
Dataflow[F2]	IoT style messages produced by Facets in JSON format
Dataflow[F3]	IoT style messages produced by Facets in JSON format
Dataflow[F4]	IoT style messages produced by Facets in relational format
Dataflow[F5]	To P3: IoT style messages produced by Facets in relational format From P3: Aggregate and forecasted IoT data in relational format
Dataflow[F6]	Data supporting service API visualizations for the Facets Insights dashboard via a service call

Transactional Intervention Flow



Transactional Intervention Flow Contd..

Item	Description
Facets [D1]	Facets transaction database
Insights [D2]	Facets Insights database
IoT Topic [D3]	Facets IoT Kafka topic
Facets [P1]	<p>Facets transaction engine consisting of:</p> <ul style="list-style-type: none">- Online Facets (also called Facets Interactive)- Facets Batch- Facets Open Access Services- TriZetto HIPAA Gateway <p>responsible for processing transactions through all the channels in the list above.</p>
Insights Agent [P2]	Facets Insights Agent responsible for consuming IoT data emitted by Facets brokering the messages to 1:n plug ins
Claim Plug In [P3]	<p>The claim plug in is part of the Facets Insights Agent. It is responsible for:</p> <ul style="list-style-type: none">- Executing 1:n machine learning models- Writing the probability result of each model to the Facets Insights database- Take 1:n action(s) for each model whose probability result exceeds that model's configured threshold
Dataflow[F1]	Facets data used to process business transactions read from and updated to the Facets database
Dataflow[F2]	IoT style messages produced by Facets in JSON format
Dataflow[F3]	IoT style messages produced by Facets in JSON format
Dataflow[F4]	The web service call from the plug in
Dataflow[F5]	Update the probability result to the Facets Insights database

Facets Insights Batch

Facets Insights Forecasts Batch

This job gathers data from the FIN_BRAG_AGGREGATE table and executes a forecasting algorithm via the fbprophet library. It should be executed on a daily basis.

The forecasting results are written to a file as insert statements to the FIN_BRFC_FORECAST table and/or to the FIN_BRFC_FORECAST table directly.

Forecasts are executed for counts and/or durations and are aggregated by:

- Service Name (SDSD_NAME)
- Application Server (BRKS_APP_SERVER)
- Calling System (BRKS_CALL_SYS_NAME)

Facets Insights Aggregate Batch



This job gathers data from the FIN_BRIM_BRKS_IOT_MERGE table and aggregates by hour by:

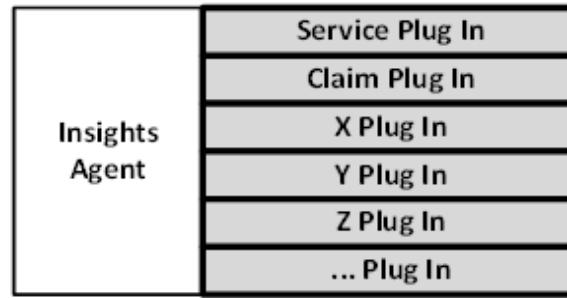
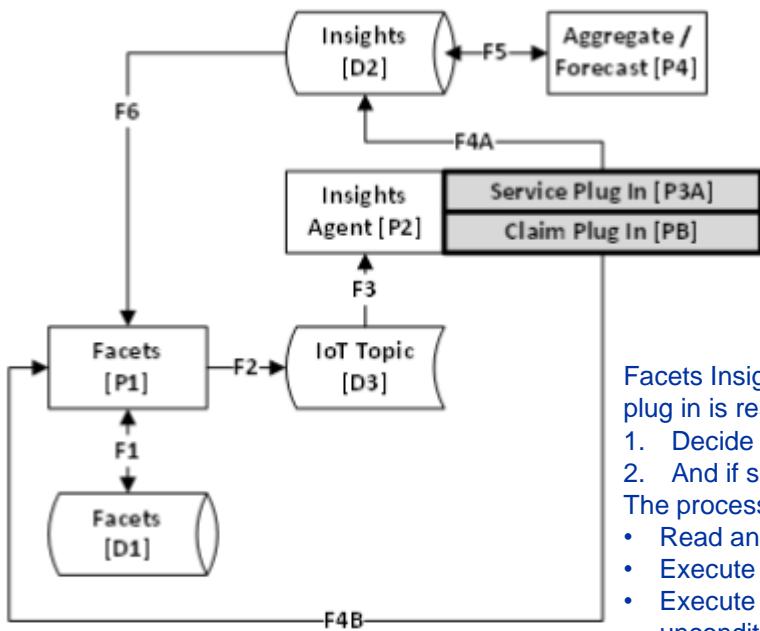
- Service Name (SDSD_NAME)
- Application Server (BRKS_APP_SERVER)
- Calling System (BRKS_CALL_SYS_NAME)

It can be executed continually, as frequently as desired, for example, every 15 minutes.

Facets Insights Processes

Facets Insights Agent

Architecture of the Facets Insights Agent



Facets Insights Agent simply is a router of messages to 1:n plug ins. Each plug in is responsible to:

1. Decide if the message is one that it needs to process
2. And if so, perform the necessary processing

The processing identified in #2 can be any number of things including:

- Read and / or write data
- Execute machine learning models
- Execute web services conditionally based on the result of the model or unconditionally

Facets Insights Agent Execution

The Facets Insights Agent is executed via a command line interface

*FacetsInsightsAgent.exe
--RegionName=XXX
--PlugIns=XXX, YYY, ZZZ
--Config[=Detail]*

Item	Description
FacetsInsightsAgent.exe	The executable that is the Facets Insights Agent.
--RegionName	The name of the Facets region on behalf of which the Facets Insights Agent will run
--PlugIns	A comma delimited set of 1:n plug ins the Facets Insights Agent should route messages to
--Config[=Detail]	A flag that indicates Facets Insights Agent should write its configuration to the console, no processing occurs. The [=Detail] qualifier is optional which tells the Facets Insights Agent to provide the configuration in a more verbose manner.

Registering Facets Insights Agent as a Windows Service

In order to register and manage Facets Insight Agent as a Windows service, a PowerShell script (FinRegisterAgentService.ps1) is provided that allow clients to register, deregister, start, stop, and check status.

Validating the configuration in console mode before establishing Facets Insights Agent as a service is essential.

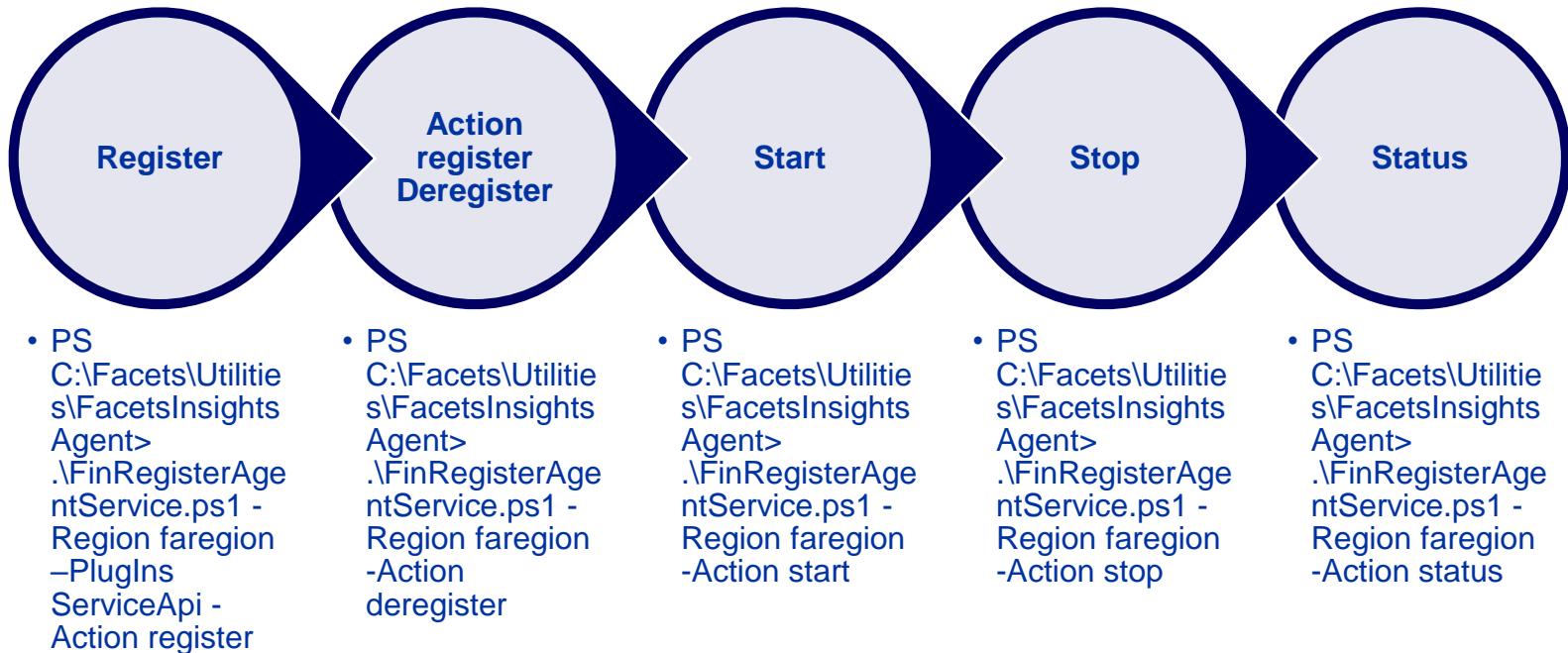


To register/deregister, execute this in a PowerShell window with Administrative rights. It is important to note that like the Facets Broker service, must register an instance for each “Facets Region” you wish to support.

Registering Facets Insights Agent as a Windows Service - Invocation Parameters

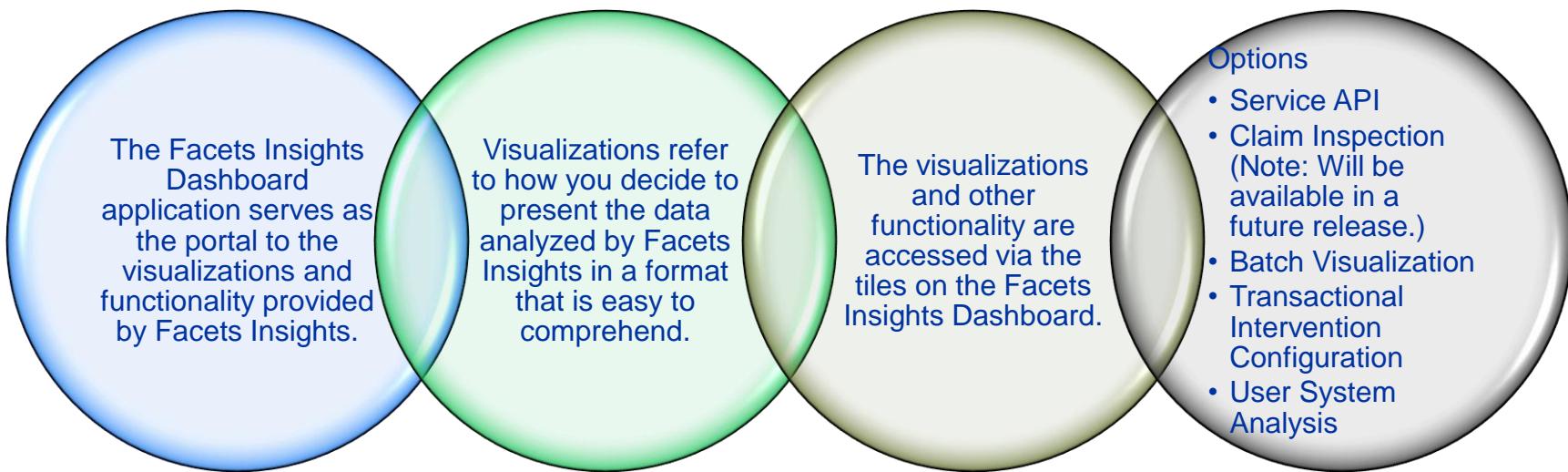
Parameter	Description
-Action	Valid Values: register, deregister, start, stop, status
-Region	Facets Region name. Required.
-Plugins	Valid Value(s): ServiceApi
-AltBinDir	Folder containing FacetsInsightsAgent.exe, if it is not where the script is located. Optional for registration.
-ServiceUser	Allows clients to specify a Windows user to run the service. User will be prompted in a dialog for the password. Optional for registration. Recommend local service account 'Network Service'
-Label	Optional label to append to name when creating instances with different plugin sets. A plugin can only be specified for a single instance, you may not have a plugin specified in more than one service entry.

Registering Facets Insights Agent as a Windows Service – Sample Executions



Facets Insights Dashboard

Facets Insights Dashboard



Facets Insights Dashboard Contd..

The screenshot displays the 'Facets Insights Center' interface. At the top, there's a navigation bar with a menu icon, the title 'Facets Insights Center', and a search bar. Below the title, a breadcrumb navigation shows 'Dashboard >'. The main content area is divided into two main sections: 'Visualizations' and 'Modeling'.
Visualizations: This section is described as providing operational performance views. It contains four blue square tiles, each with a white chart icon and text:

- Service API
- Claim Inspections
- Batch Visualization
- User System Analysis

Modeling: This section is described as providing an interface for automated machine learning model creation and management. It contains one blue square tile with a white chart icon and text:

- Transactional Intervention Configuration

Service API Visualization

A major part of Facets Open Access is the Facets Web Services Library which offers customers a wide variety of service APIs that provide access to Facets data and functionality.

The Services API component of Facets Insights provides visibility into the performance and utilization characteristics of the Facets Web Services Library.

In turn, each of the tabs has two tabs:

- All Calls
- App Server
- Calling System
- System Performance

- **Aggregated:** Displays the raw data
- **Over Time:** Displays the data over a period of time.

Available Functions for Service API

Tips

- Hovering over any of the lines, bars or columns on a graph displays a tool tip, a description and the value of the data point on the line, bar or column.

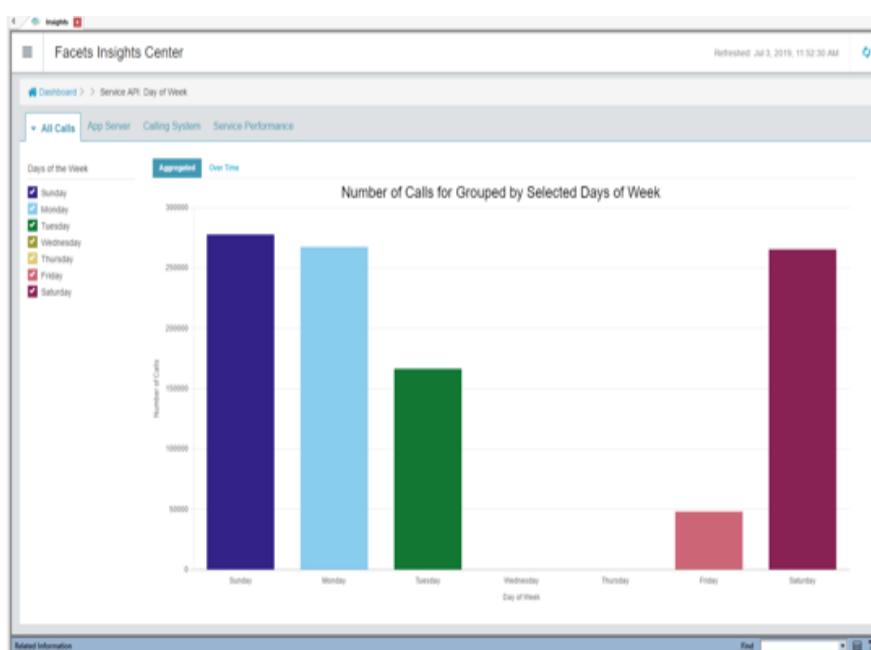
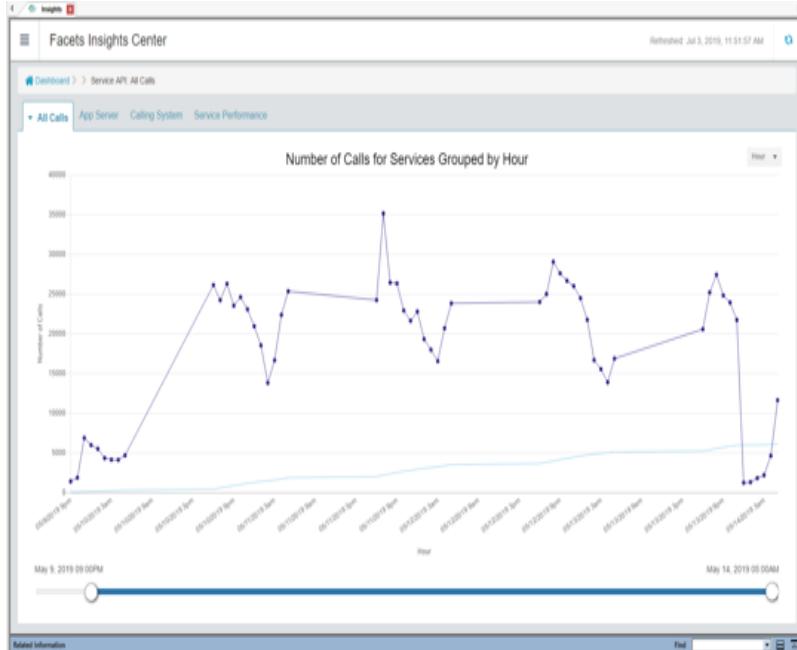
Date Range

- All graphs that show data over a period of time include a date range slider at the bottom of the screen.
- That date range can be adjusted from either side by sliding the endpoint left or right.

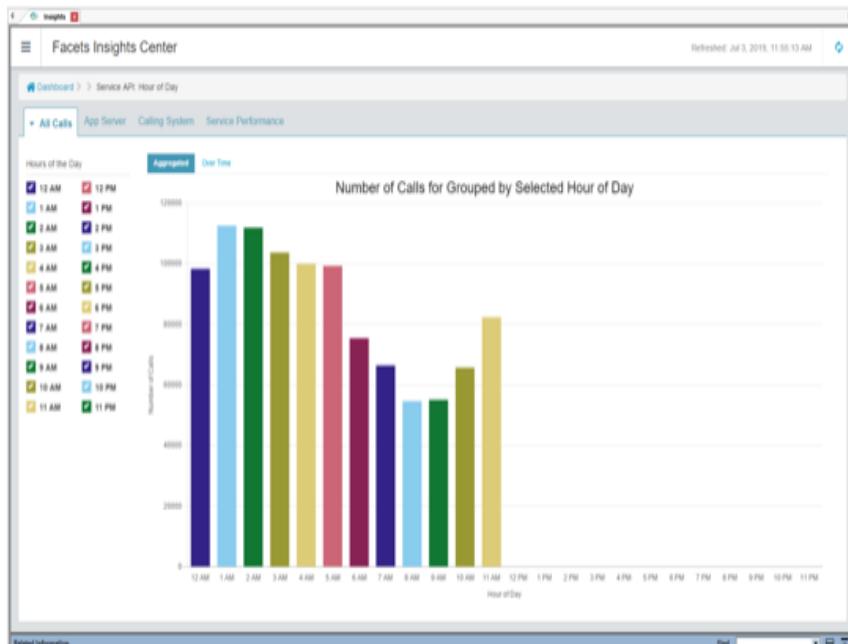
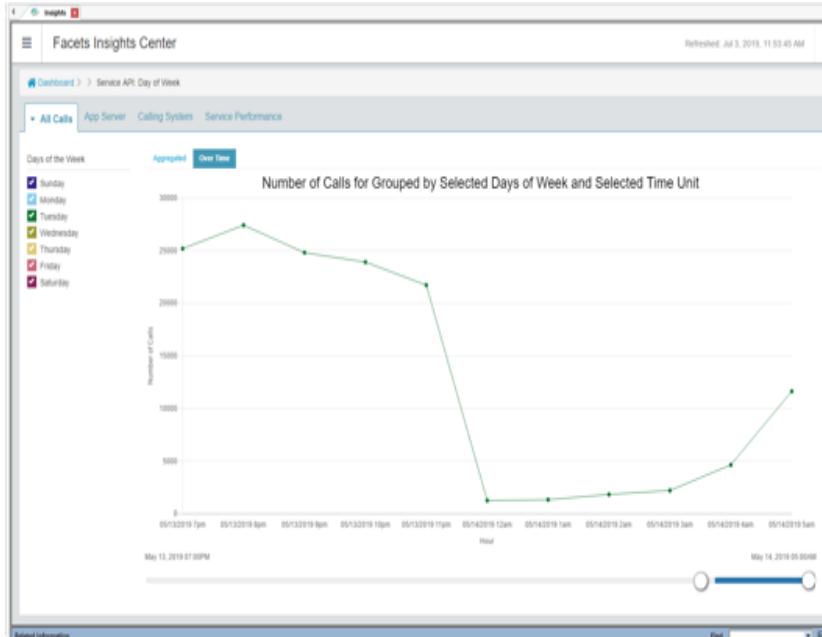
Time Unit

- All graphs that show data over a period of time include a drop-down menu from which the user can select the unit of time to be presented on the graph.

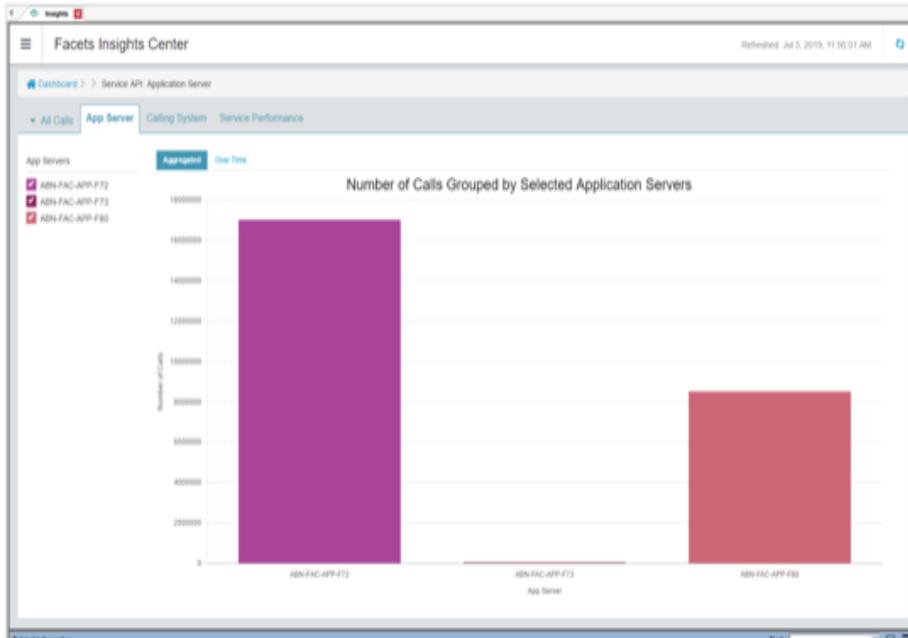
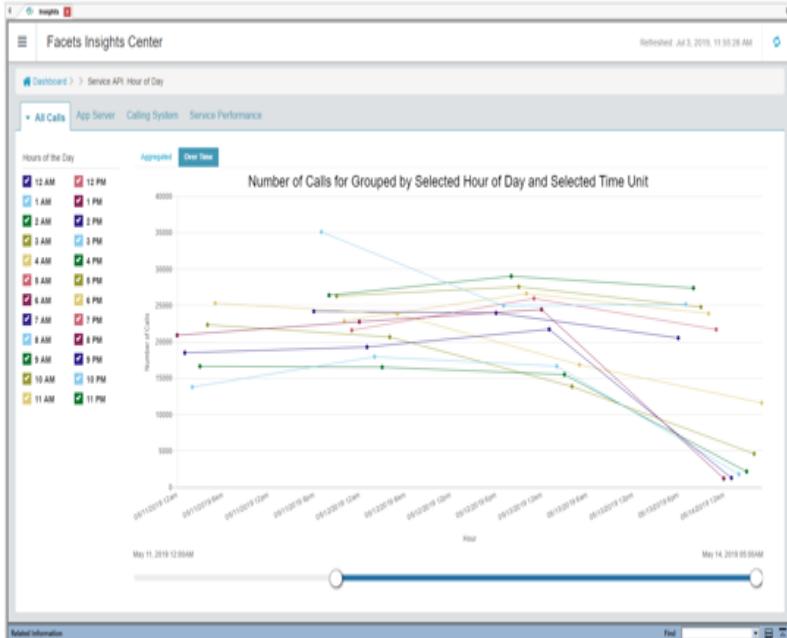
Service API



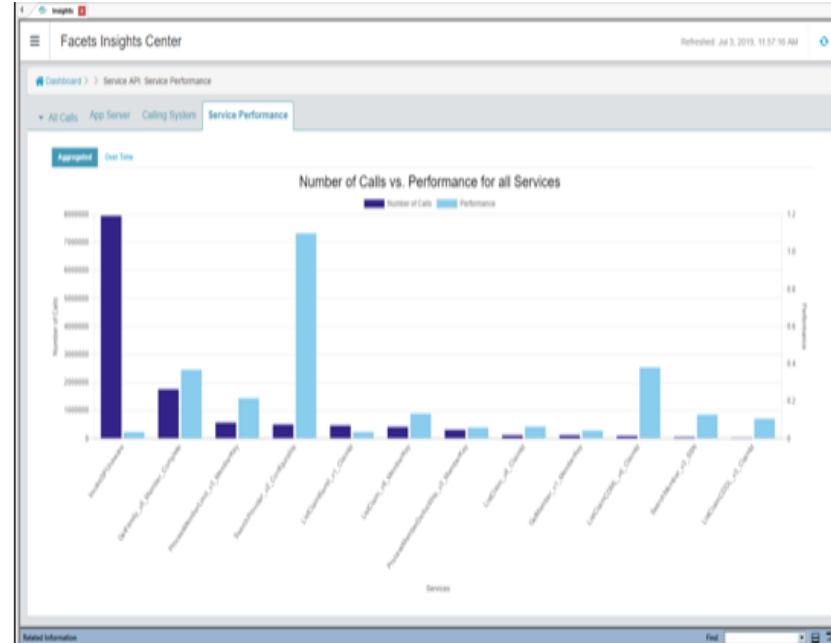
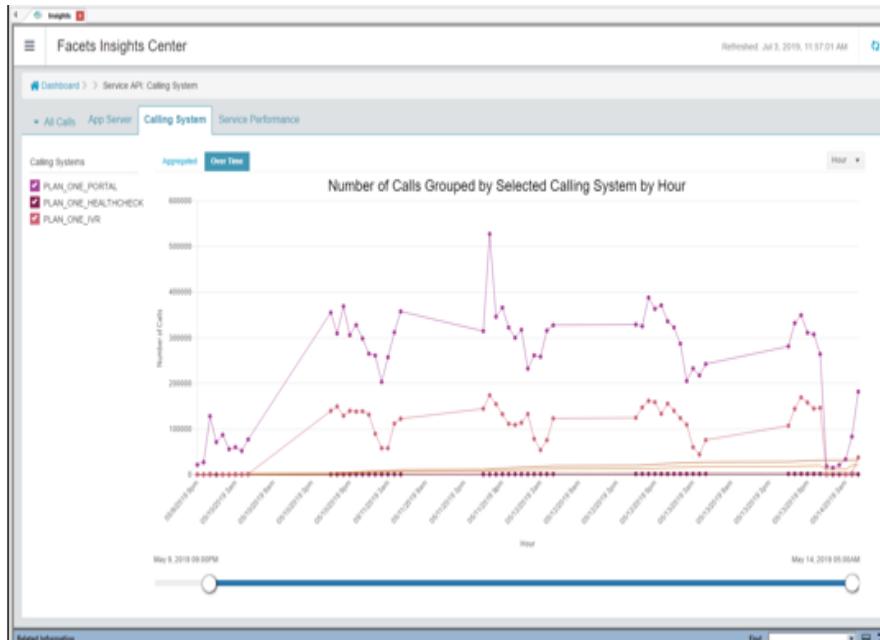
Service API Contd..



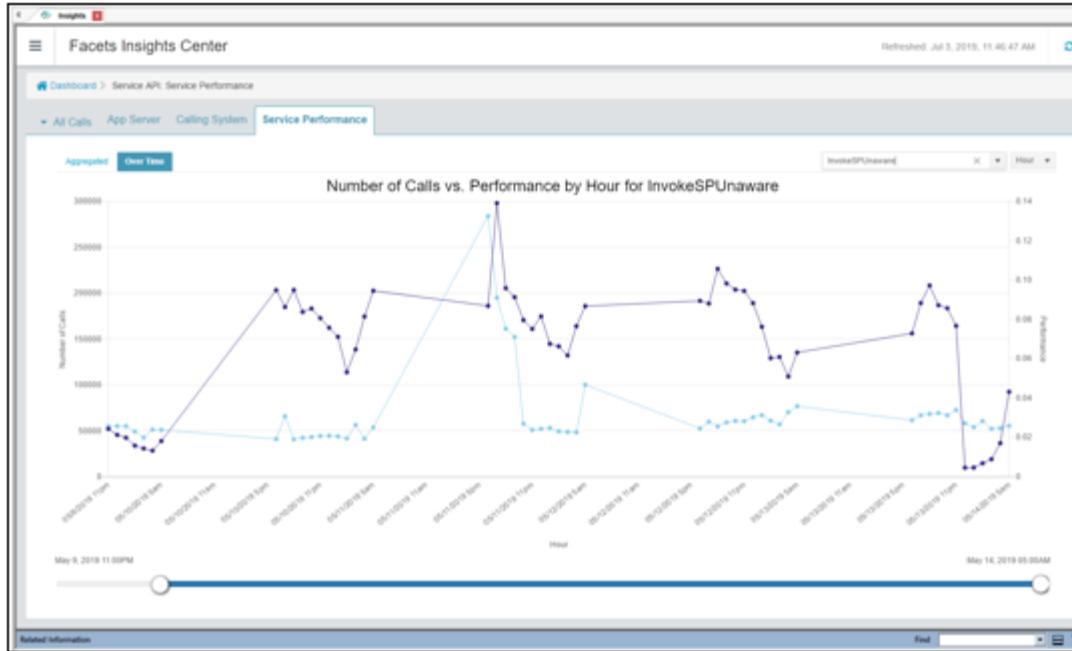
Service API Contd..



Service API Contd..



Service API Contd..



Batch Visualization

Facets Insights includes a visualization that allows customers to understand the volume, throughput and response time of Facets batch jobs individually and over time.

Performance utilization of completed batch jobs can be measured using defined criteria.

A new Batch Visualization display has been added to the Facets Insights Dashboard where you can select a batch job and desired parameters to view the batch performance over time.

Transactional Intervention Framework

Key component of Facets Insights that introduces Artificial Intelligence (AI) and Machine Learning (ML) into the fabric of Facets transactional processing.

This adds the ability for Facets to apply probabilistic logic in a near real-time basis to the existing deterministic logic that customers are able to configure within Facets.

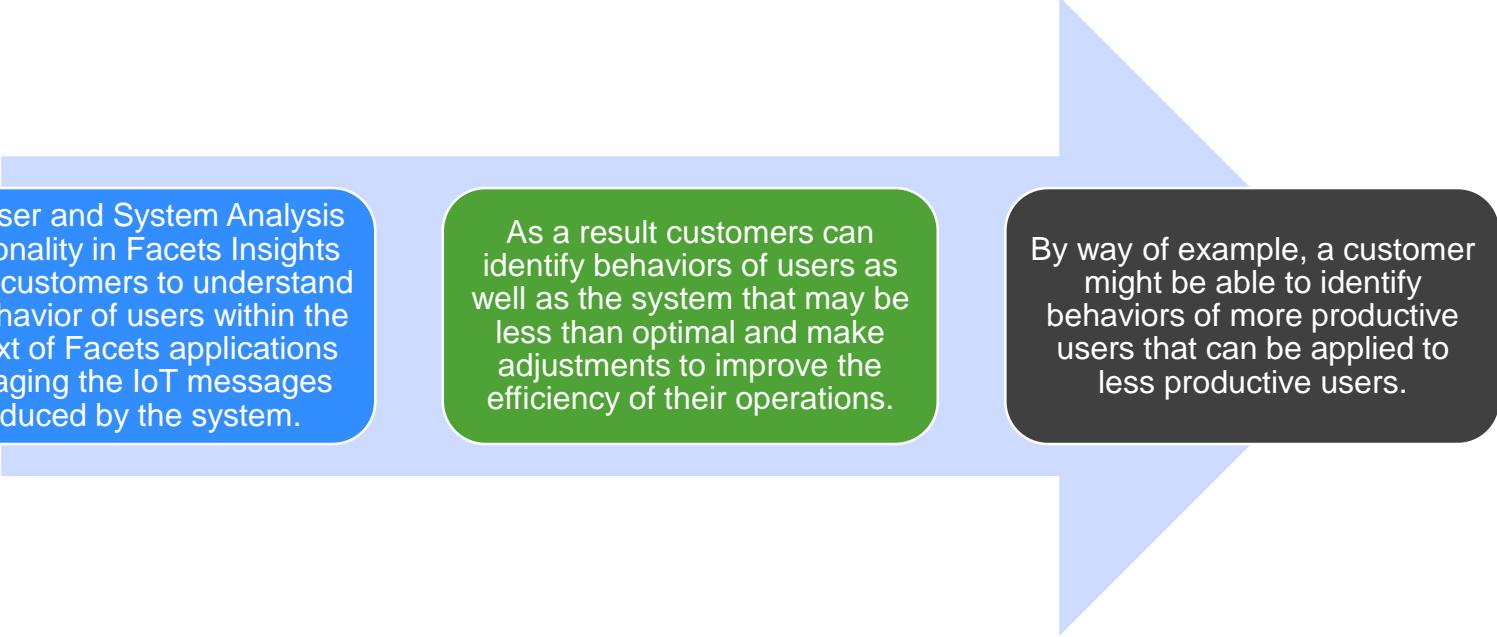
Machine learning models created from any source, Cognizant, third party, customers, etc., can be associated with events triggered within Facets transactional processing.

The results of these models can cause Facets Insights to instruct Facets to take one to many actions that influence the outcome of a business transaction, such as claims processing.

Transactional Intervention Framework in Facets Insights allows customers to leverage their own machine learning models.

These models are consulted at the time a claim is saved. If the probability the model returns exceeds the user defined threshold Facets can then be instructed to reprocess the transaction with a different claim status reason code.

User System Analysis



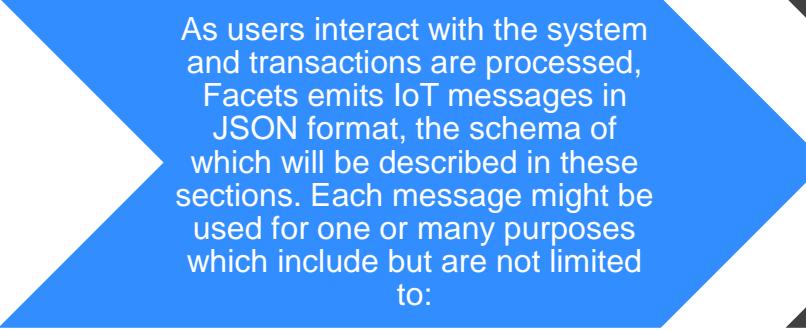
The User and System Analysis functionality in Facets Insights allows customers to understand the behavior of users within the context of Facets applications leveraging the IoT messages produced by the system.

As a result customers can identify behaviors of users as well as the system that may be less than optimal and make adjustments to improve the efficiency of their operations.

By way of example, a customer might be able to identify behaviors of more productive users that can be applied to less productive users.

IoT Messages

IoT Messages



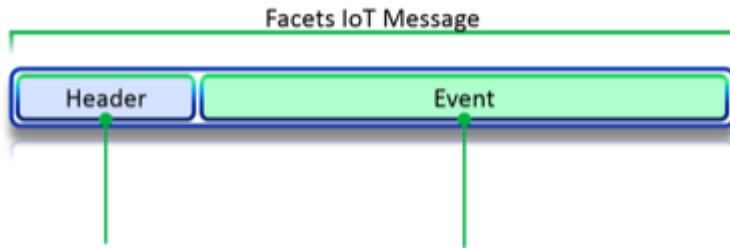
As users interact with the system and transactions are processed, Facets emits IoT messages in JSON format, the schema of which will be described in these sections. Each message might be used for one or many purposes which include but are not limited to:

- Performance and utilization analysis
- Pattern identification
- Anomaly detection
- Instigating machine learning and artificial intelligence processing



Facets produces these IoT messages from any and all processing channels

Message Overview



The data elements in the Header section are the same for each message

The Event section is comprised of its own set of data elements as well as a Data section that contains contextual data about that specific event type and instance

```
{  
  "TZG_MSG_HDR": {  
    "VERSION": "570R2",  
    "MESSAGE_ID": "6590884B-568C-4232-8333-2EE5F3B13C88",  
    "TENANT_ID": "Trizetto - MLM",  
    "TENANT_REGION": "fqmfacmast57x",  
    "PRODUCER": "FACETS",  
    "CREATE_DATE": "12/30/2019 14:01:59.690",  
    "USER_ID": "FACETS",  
    "ACTIVITY_ID": "C108DAC6-D975-4AFF-9ABF-19DA3A5E9DF7",  
    "SYIN_INST_CALLER": 1836216,  
    "SYIN_INST": 1836216,  
    "APP_ID": "$SGN"  
  },  
  "EVENT": {  
    "ID": 1,  
    "CATEGORY": "System",  
    "NAME": "SysSyin",  
    "TIMING": "B",  
    "DATA": { ... } // 2 items  
  }  
}
```

Message Header Block

Element	Description
ACTIVITY_ID	Defines a thread of processing activity. The ACTIVITY_ID could originate within a Facets process or outside a Facets process.
APP_ID	The PZAP_APP_ID of the Facets process that produced the message.
CREATE_DATE	The date and time the message was produced.
MESSAGE_ID	A unique identifier in the form of a GUID.
PRODUCER	Identifies the source of the message. Messages produced by Facets are valued with "Facets."
SYIN_INST	The SYIN_INST of the Facets process that produced the message.
SYIN_INST_CALLER	The SYIN_INST value of the application that invokes the application producing the message.
TENANT_ID	Populated from the Facets license file to identify the client.
TENANT_REGION	The Facets region that the messages was produced from.
USER_ID	The USUS_ID of the Facets process that produced the message.
VERSION	The version of Facets that produced the message, for example, 5.7 R2

Message Event Block

Element	Description
ID	The ID is a unique numerical representation of the combination of the <i>CATEGORY</i> and <i>NAME</i> elements described in this table.
CATEGORY	Describes a high level of organization of the message. By way of analogy, it can be considered the "last name" of the message. It is a way to organize a set of messages into a logical grouping.
NAME	Describes a lower level of organization of the message. By way of analogy it can be considered the "first name" of the message.
TIMING	Messages can be used to express durations or simply a single point in time. This data element defines the message as: <ul style="list-style-type: none">· [B]eginning a duration· [E]nding a duration· [P]oint in Time

Message Event Block Contd..

Element	Description
DATA	<p>The <i>DATA</i> element of the Event Block stores contextual data about the message. This block varies in schema and content depending on the message <i>CATEGORY</i> and <i>NAME</i>. Details specific to each <i>CATEGORY</i> / <i>NAME</i> combination can be found in Appendix A (IoT Messages). For example, the message:</p> <ul style="list-style-type: none">•<i>CATEGORY</i> : UI•<i>NAME</i> : PanelSwitch <p>describes when a Facets user switches from one panel to another. Out of context, that message can describe only the act of switching from one panel to another, but it does not provide any information as to what panel was switched from and what panel was switched to. The <i>DATA</i> element of this message contains that information. So, with the <i>DATA</i> element, the message becomes much more valuable and useful in that it not only describes the act of switching from one panel to another but also describes the source panel and target panel of the panel switch.</p>

Message Concepts

Facets IoT messages can be evaluated in a variety of ways:

Singular IoT message

- Use as a trigger or for single units of information.

Sequential IoT messages

- Use to understand patterns & behaviors of message sequences.

Aggregated IoT messages

- Use to understand patterns & behaviors of accumulations of messages.

Combining two or more Facets IoT messages facilitates the understanding of the following concepts:

Threads of Execution

Unit of Work

Duration

Message Concepts – Threads of Execution

Category	Description
ACTIVITY_ID	<p>A SYIN_INST_CALLER can be comprised of one to many ACTIVITY_IDs. It can be thought of in terms of a single process be it a user of the Facets interactive system or a single batch engine or orchestration process.</p> <p>Facets IoT messages are partitioned in the Kafka stream by ACTIVITY_ID in order to distribute the production of messages most efficiently.</p>
Application	<p>An instance of Facets application that is executed within a given <i>Activity</i>. It is important to keep in mind that multiple applications or even multiple instances of the same application can be executed within a given <i>Activity</i>. The thread of execution at the application level can be tracked via the SYIN_INST.</p>
SYIN_INST_CALLER	<p>The SYIN_INST number of the Facets process that is initiating the processing. This is the highest level of organization of Facets IoT messages.</p>

Message Concepts – Unit of Work

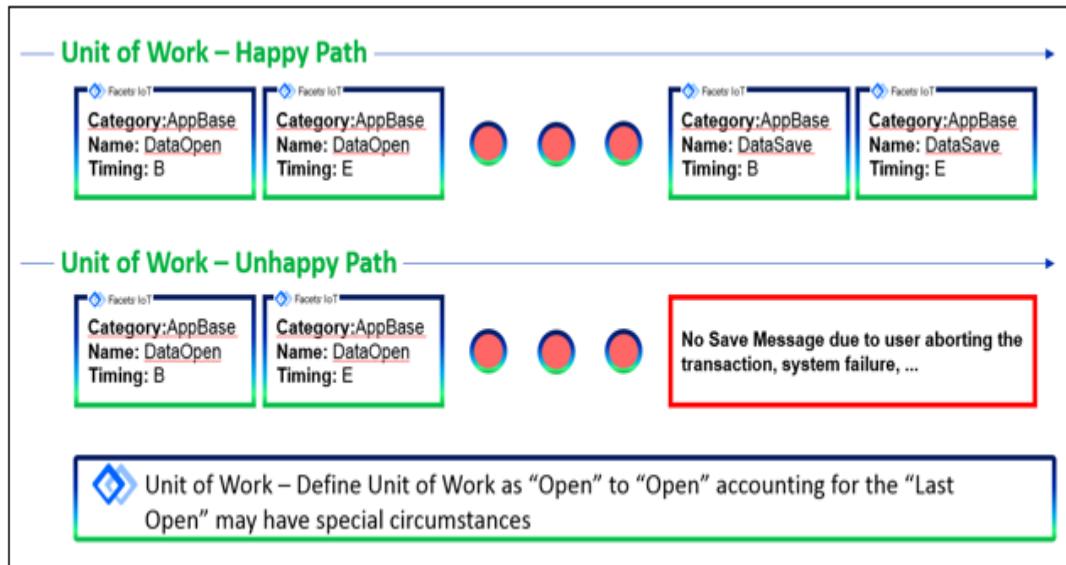
Fundamentals that can be applied generically to identify a unit of work:

- Identify the beginning of the desired unit of work.
- Measure the duration of a unit of work from the beginning of one unit of work to the beginning of the next. This compensates for the unpredictability of a defined end of the unit of work.
- Account for the real possibility that the last unit of work in the sequence may not “end at all.” In other words, there would be no “next begin.”

The beginning of a business transaction is usually well-defined. The ending is often less defined and may need to be expressed in terms of:

- A defined action by the user
- The beginning of the next transaction
- The end of action(s) for a given time period (day, hour, etc...)

Message Concepts – Unit of Work Contd..



Unit of Work - Beginning

- The beginning of a unit of work must be predictable and objective. Examples might be:
- A user opening a record
- A process beginning a business transaction such as adjudicating a claim or rating a subscriber

Unit of Work - Ending

- The ending of a unit of work might not be as predictable but must have some set of objective criteria.
- The reasons for unpredictability include failures and alternative endings such as closing applications, logging out and users taking other actions.

Message Concepts – Duration

Each IOT message contains a TIMING data element that reflects the nature of the timing of the message. The valid values are:

[B]eginning a duration

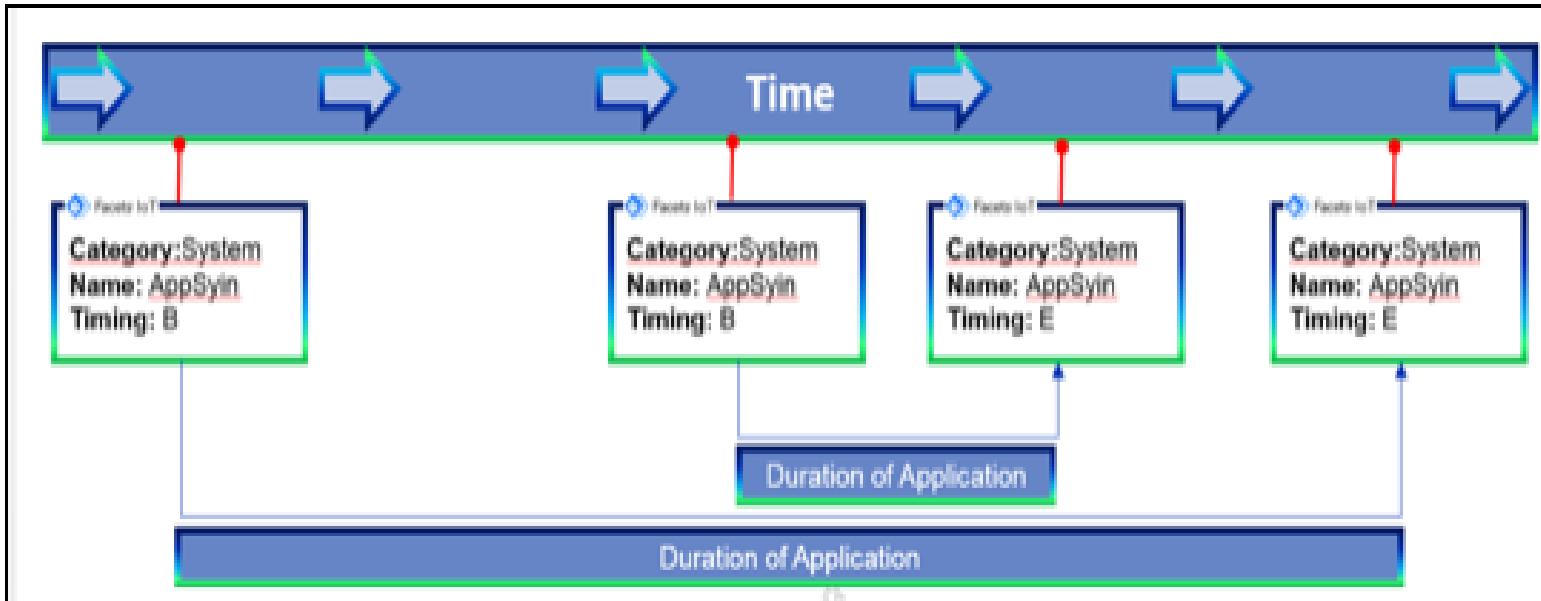
[E]nding a duration

[P]oint in Time



Duration can be expressed by subtracting the time of the Beginning (B) message from the time of the matching End (E) message. The Point in Time (P) messages are not intended to describe a duration, rather, they represent something that happened at a given point in time.

Message Concepts – Duration Contd..



Message Concepts – Duration Contd..

To describe duration, Begin (B) and End (E) messages MUST be matched by Category and Name sequentially.

The Begin and End messages MUST be within the same Activity ID and SYIN_INST.

Although the likelihood of there being an *END* for each *BEGIN* is extraordinarily high, there is no guarantee that this will occur. Several scenarios may cause Facets to encounter an error after a *BEGIN* is created but before the matching *END* is created. Therefore, consumers of the messages must consider the possibility of a sequence that might look as follows (assuming the *ACTIVITY_ID*, *SYIN_INST*, *CATEGORY* and *NAME* are the same for the messages):

- *BEGIN*
- *BEGIN*
- *END*
- *BEGIN*
- *END*

In this example, the *END* of message one was never created. Individual consumers need to determine how to proceed in these circumstances, as they are plausible situations.



Q & A!!!!

Cognizant
Learning Services

Thank You!!

Appendix

Plugins Used

Value	Description
ServiceApi	This plug-in consumes IoT messages generated by Facets Services and writes the data into appropriate Insights tables for ML processing.
Claim	The claim plug-in watches for 'PostSaveClaim' messages of CLCL_CL_TYPE 'M' or 'D', and a CLCL_CUR_STS of '01'. Messages are then send via REST call to an ML evaluator for processing.
Batch	<p>The batch plug-in captures batch job messages with an event category of 'System' having an event name within the following list:</p> <ul style="list-style-type: none">"ActionBatchInfo","ActionSyin","AppClose","AppOpen","AppSyin","JobBatchInfo","JobSyin","RunControl","StepBatchInfo","StepSyin","SysSyin" <p>and writes the data into the appropriate Insights tables for ML processing.</p>

Console Mode Example

```
C:>FacetsInsightsAgent.exe --Region=fdmfacfinarchdev --Config
#####
# Facets Insights Agent - Begin
#####
# Region: fdmfacfinarchdev
# Verbose: False
# BaseDir: c:\Facets\Utilities\FacetsInsightsAgent\
# LogDir: C:\Facets\Regions\fdmfacfinarchdev\Output
#LogFile: C:\Facets\Regions\fdmfacfinarchdev\Output\Fia_fdmfacfinarchdev_2019-07-01T00-00-00.log
#####
# Kafka Settings
# Topic: IoT_4
# Security Protocol: SSL
# CA Location: \\\\Certs_QA\\ca-cert
# Client Certificate Location: \\\\Certs_QA\\ABN-FAC-DATPUB1_client.crt
# Client Key Location: \\\\Certs_QA\\ABN-FAC-DATPUB1_client.key
# Servers:
# 10.90.72.131:1801
# 10.90.72.131:1802
# 10.90.72.131:1803
# Offsets:
# Value: Current
# Bypass MessageTypes:
# SearchDisplay
# InquiryDisplay
# TCSExecution
#####
# Plug-Ins:
plugins Count [1]
ServiceApi:
Region[fdmfacfinarchdev]
#####
# Facets Insights Agent - End (o)
#####
```

Running Console

- When invoked without the -h or --Config options the application will first display the configuration, then ask for confirmation to run.
 - If allowed to continue the following will happen:
 - Application will connect to Kafka, Load Plugins and execute each for a read message.
 - For the ServiceApi plugin, if the message is applicable it will write to the insights database. Periodically it will dump out Kafka statistics.
 - To terminate you type Ctrl-C in the console window, and the program will complete gracefully.
-
- *C:\Facets\Utilities\FacetsInsightsAgent>FacetsInsightsAgent.exe --Region=fdmfaciarchdev*

IoT Messages by Category

Category	Description
AppBase	Messages produced by acting upon a record.
Billing	Messages produced by applications specific to Facets Billing.
Claims	Messages produced by applications specific to Facets Claims.
Extension	Messages produced by the execution of an extension via the Facets extensibility framework. This would include the execution of custom extensions written by a customer as well as componentry such as the Facets Integrated Pricer that is executed via the same framework.
Inquiry	Messages produced by performing an action in an inquiry specific application.
Search	Messages produced by as a result of a user performing a search via the Facets user interface.
Service	Messages produced by the execution of a Facets Open Access service.
System	Messages produced by the Facets framework no matter the processing channel.
TCS	Messages produced by the Facets specific interface to the TriZetto Communications System
Workflow	Messages produced by the Facets specific interface to Facets Workflow.
UI	Messages produced by as a result of a user navigating the Facets user interface.



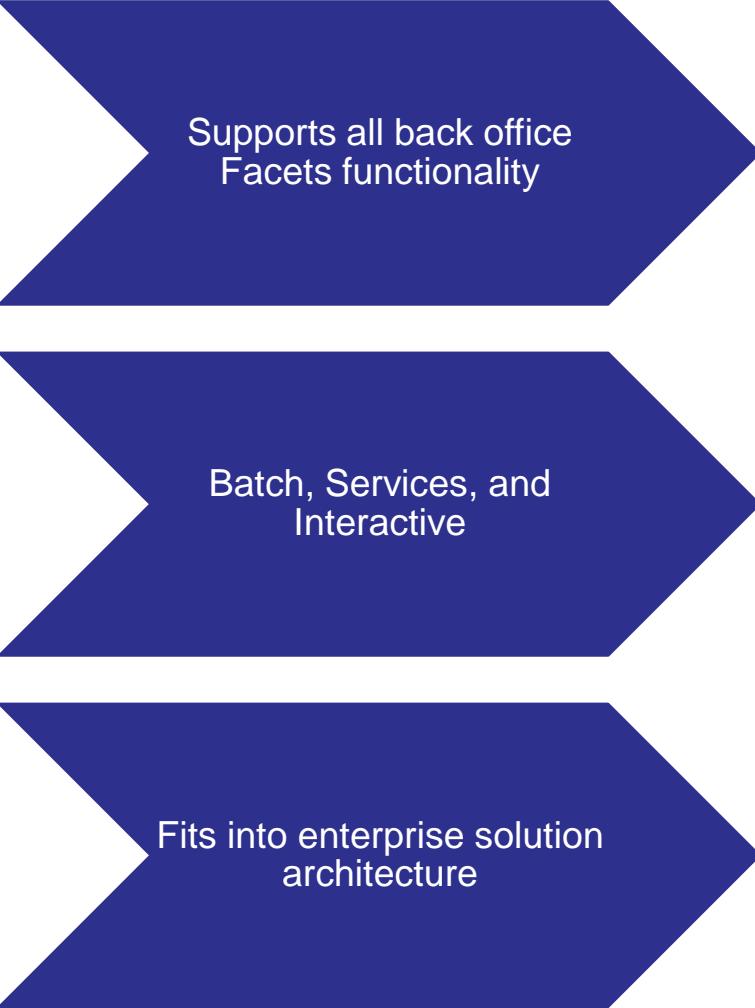
Batch Architecture

Learning Services

Agenda

- Facets Virtual Server
- Batch Architecture Overview
- Region
- Keyword File
- Bulk Data Load Processes
- Custom Jobs

Facets Virtual Server Overview

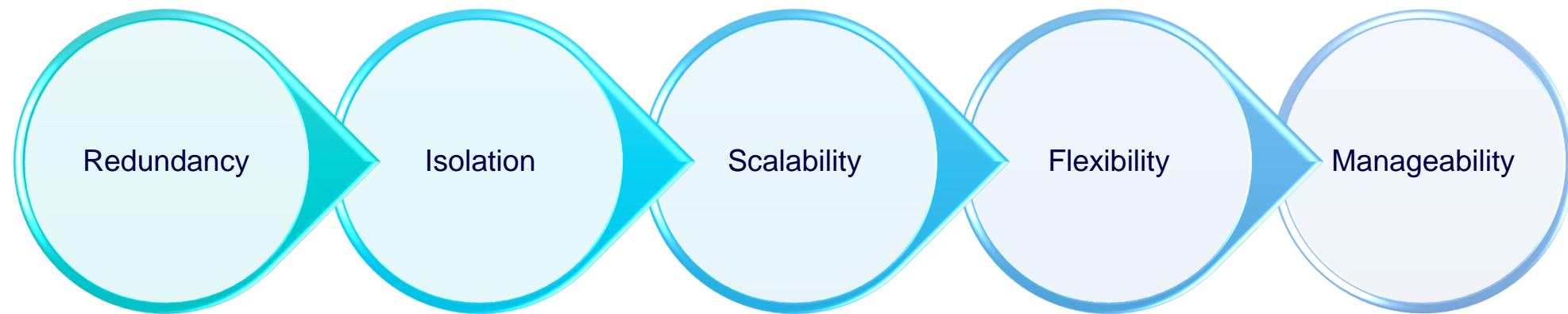


Supports all back office
Facets functionality

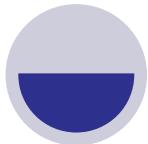
Batch, Services, and
Interactive

Fits into enterprise solution
architecture

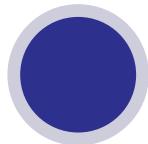
Facets Virtual Server Benefits



Redundancy



No single point of failure



Configuration supports
redundancy at all levels:

Application Server
File Server
Database



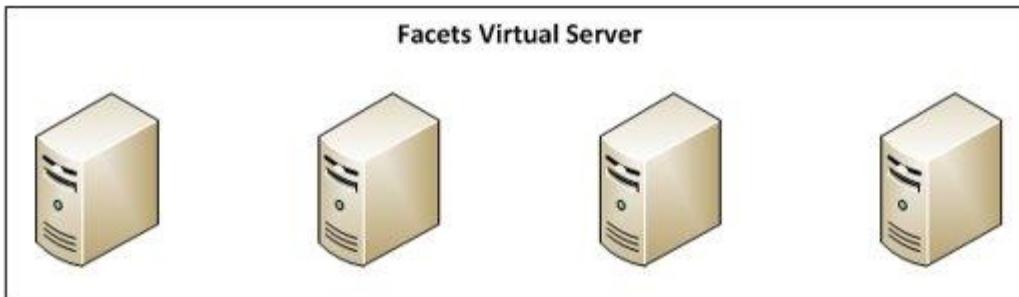
Job Scheduler



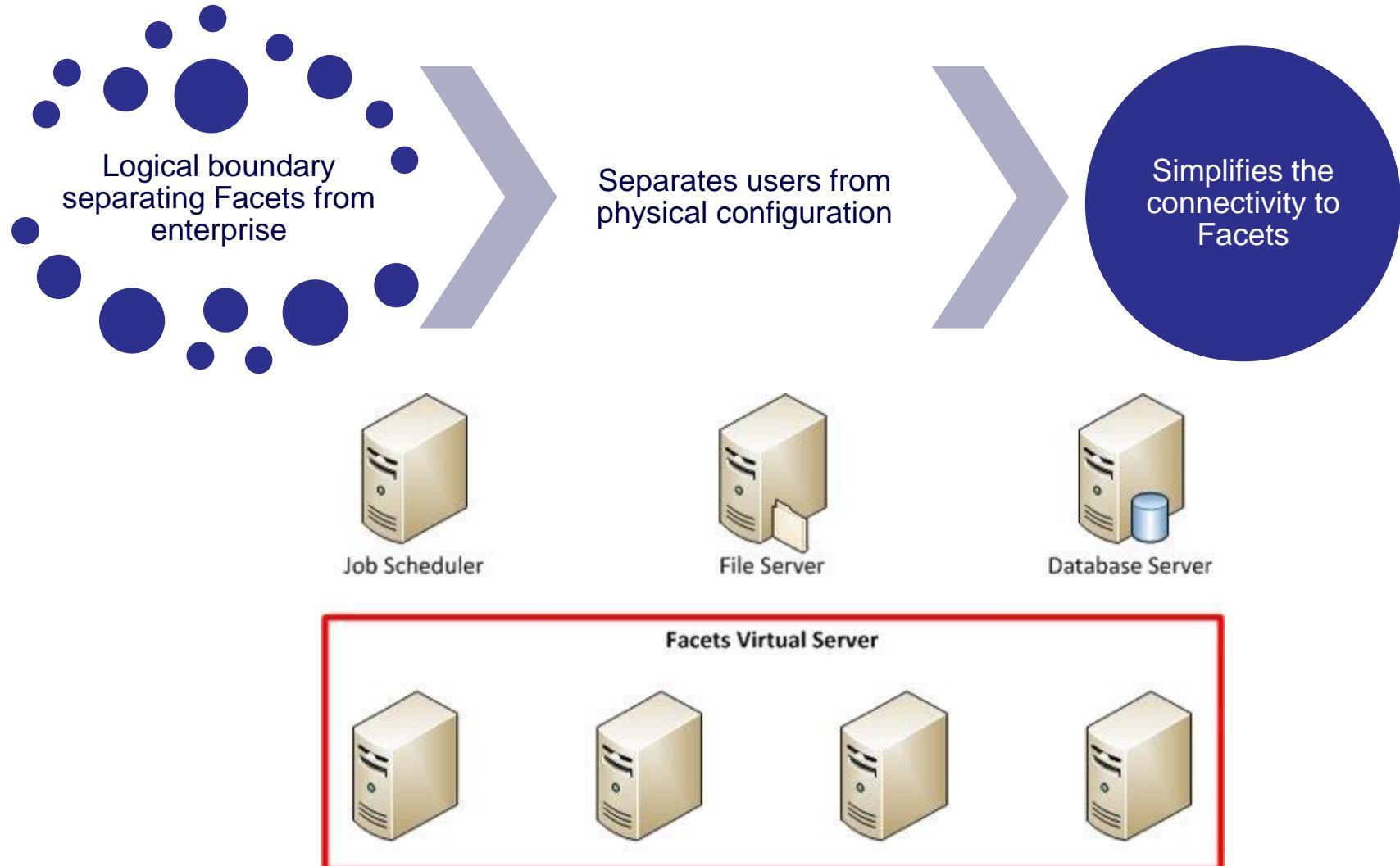
File Server



Database Server



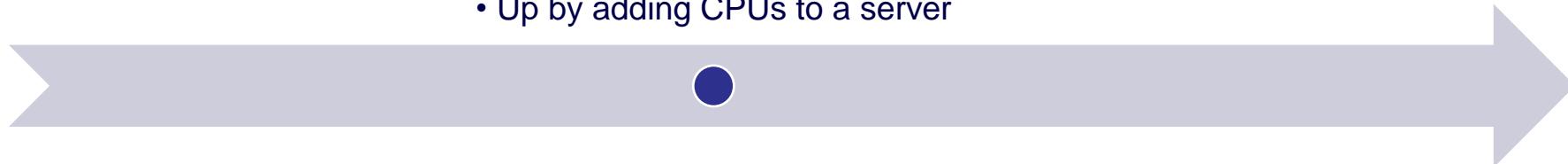
Isolation



Scalability

Scale Application Servers

- Out by adding more servers
- Up by adding CPUs to a server



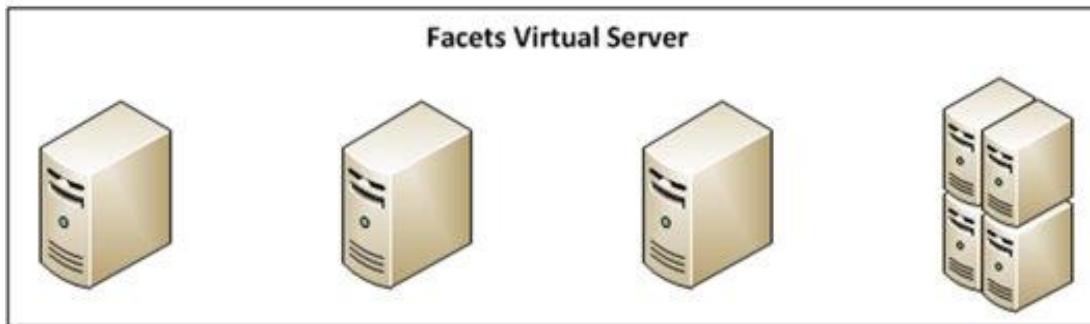
Job Scheduler



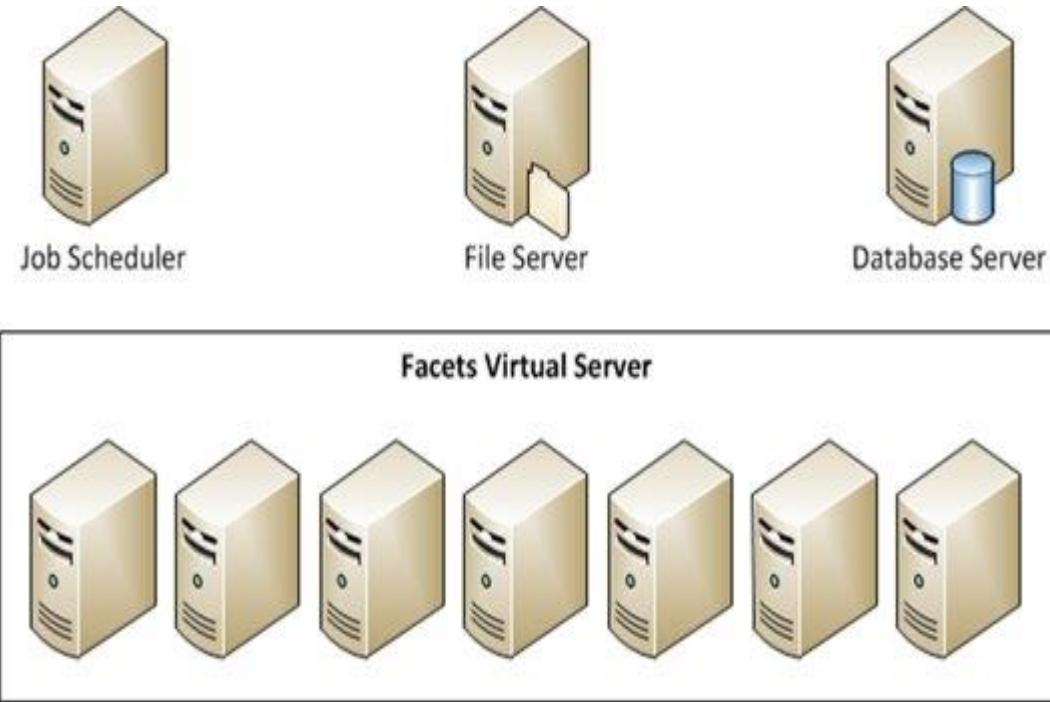
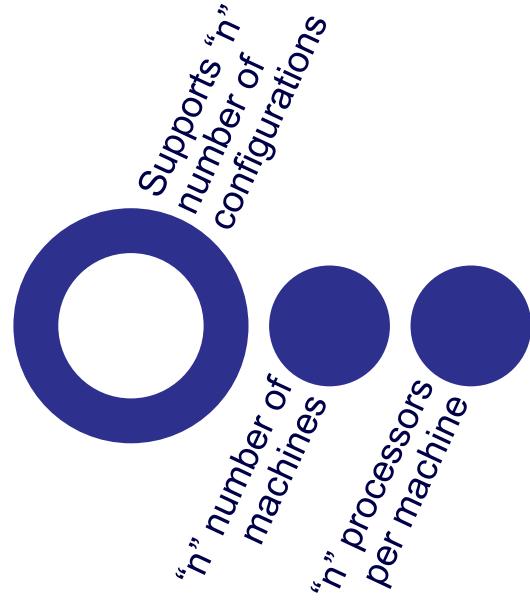
File Server



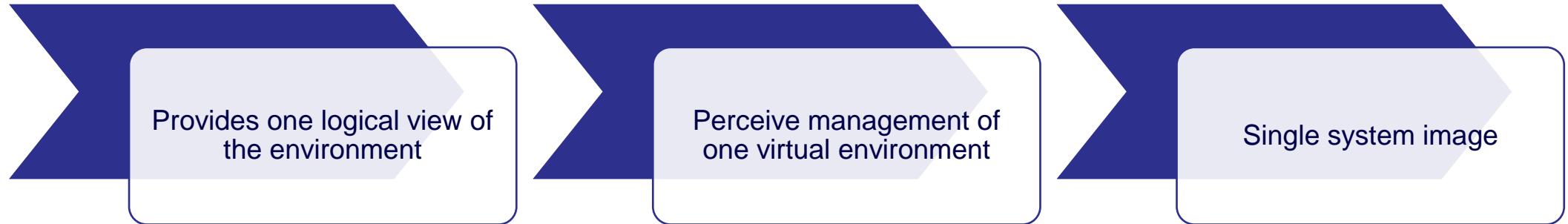
Database Server



Flexibility



Manageability



Job Scheduler



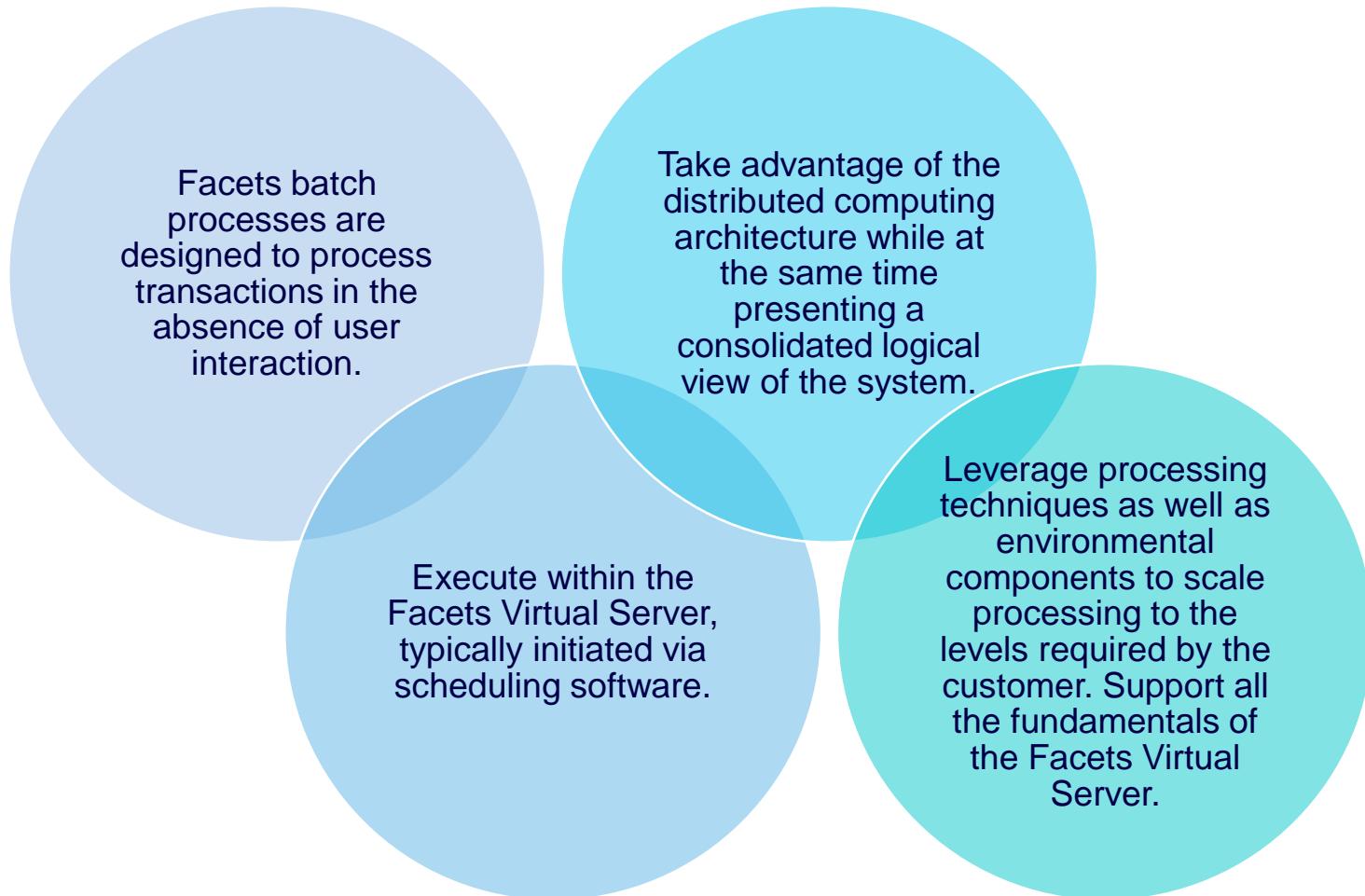
File Server



Database Server



Batch Overview



Batch Installation

Application server installation:

- Creates:
 - Job Manager
 - Region
 - Dedicated logon with Facets Only Security encryption on password
- Provides:
 - xml files
 - Runtime libraries
 - pzb files

Directories

Created during the install:

- Customer:
 - Runbook
 - Script
- Regions:
 - System configuration file
- Utilities:
 - Region Manager Application
 - ErySYS0DbLastUpdTrigger.vbs
 - System Log
- System:
 - Bin64
 - Config
 - Setup
 - State
 - Work

Region Overview

- Features of the Facets region:
- All components required to run Facets
 - Stored in a Region Store
 - Physically located in ErSystCfgSystem###.xml
 - One centralized Region Store per Region



1 Database



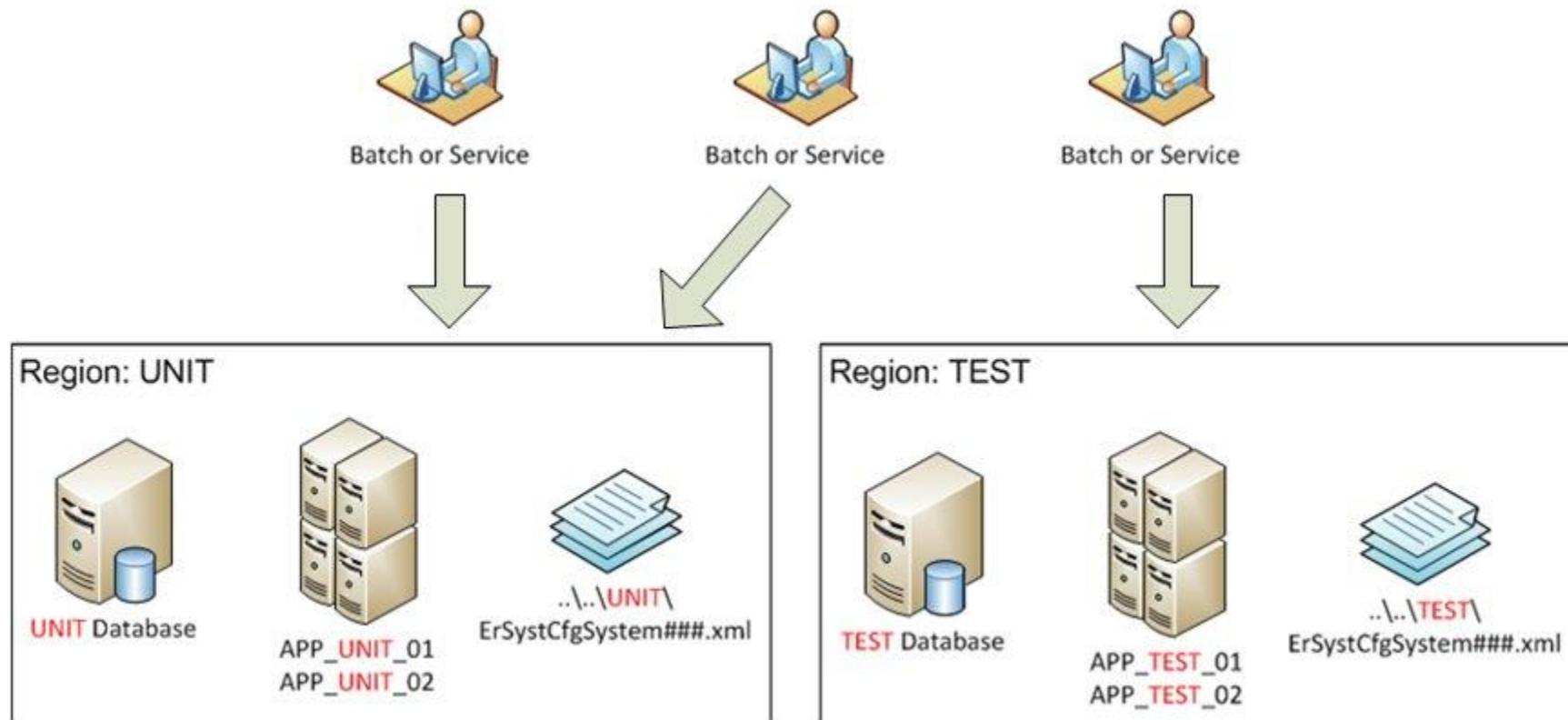
1:n Application Servers



1 Set of Configurations

Run-Time

Facets executes against one specific region.



Region Directory

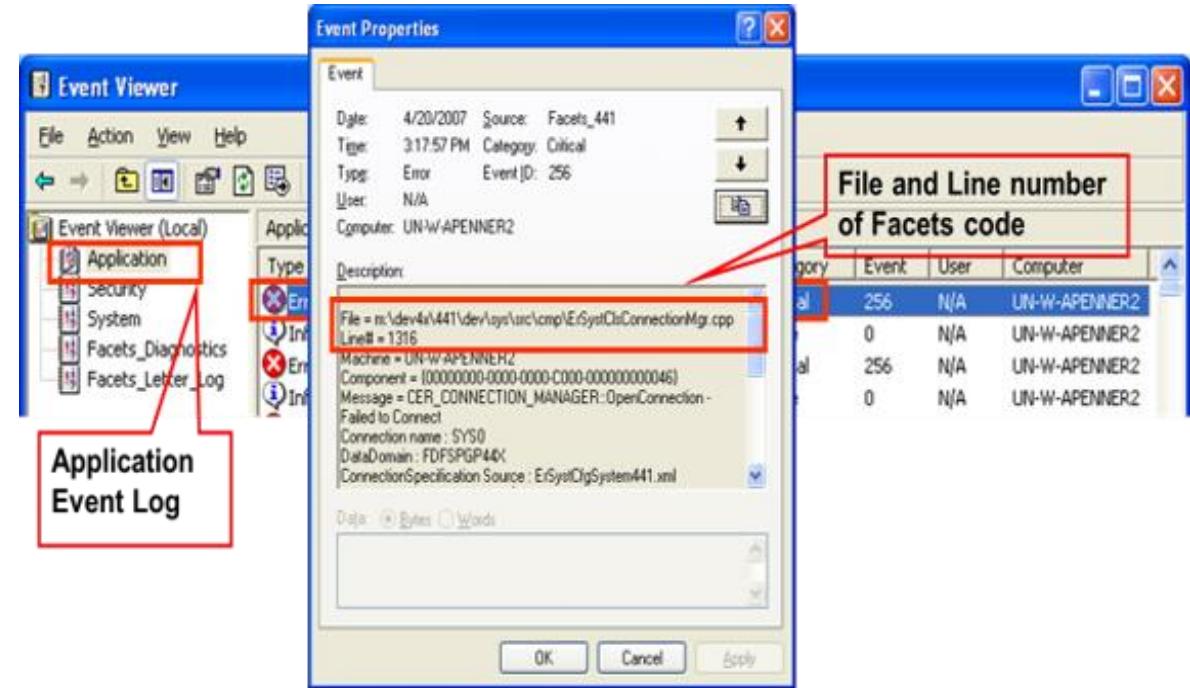
Characteristics of the Region Directory:

Houses 1:n Region Stores of available regions

Physically a centralized location accessible to all application servers

Region Stores can share resources

Event Log



Using the event viewer:

- View on APP server
- Control Panel>Administrative Tools
- Use Application log
- File and line # of Facets code

Managing Regions

Considerations of managing regions:

Installation

- Choose to create new region or join existing region
- Ensures consistent configuration in distributed environment

Creating a Region

- Gather all criteria to define a region at installation

Joining a Region

- Name the region to join during installation
- Facets adds application server to the specified region

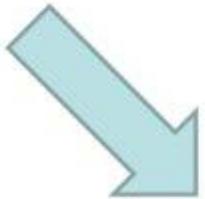
Region Installation



Server A

Action: Create a Region

- Define Region Criteria
- Create Region store
- Add Server A to Region



Region Store

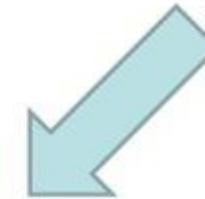
- Server A
- Server B



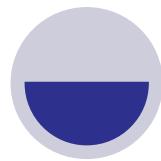
Server B

Action: Join a Region

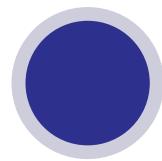
- Add Server B to Region



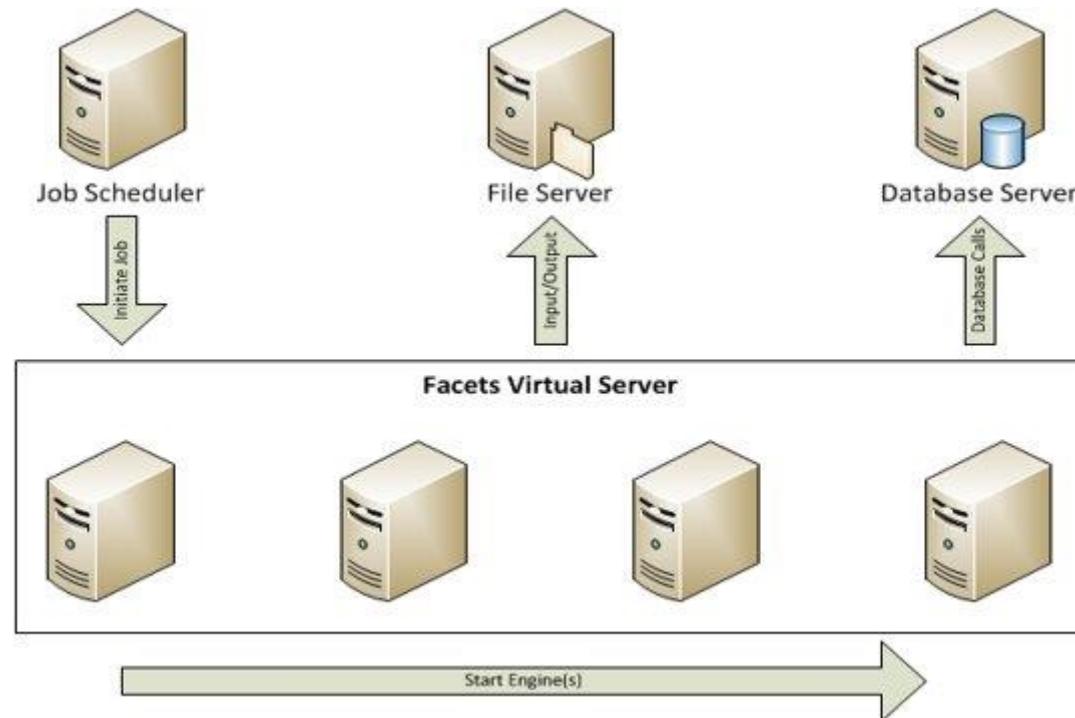
Batch Execution



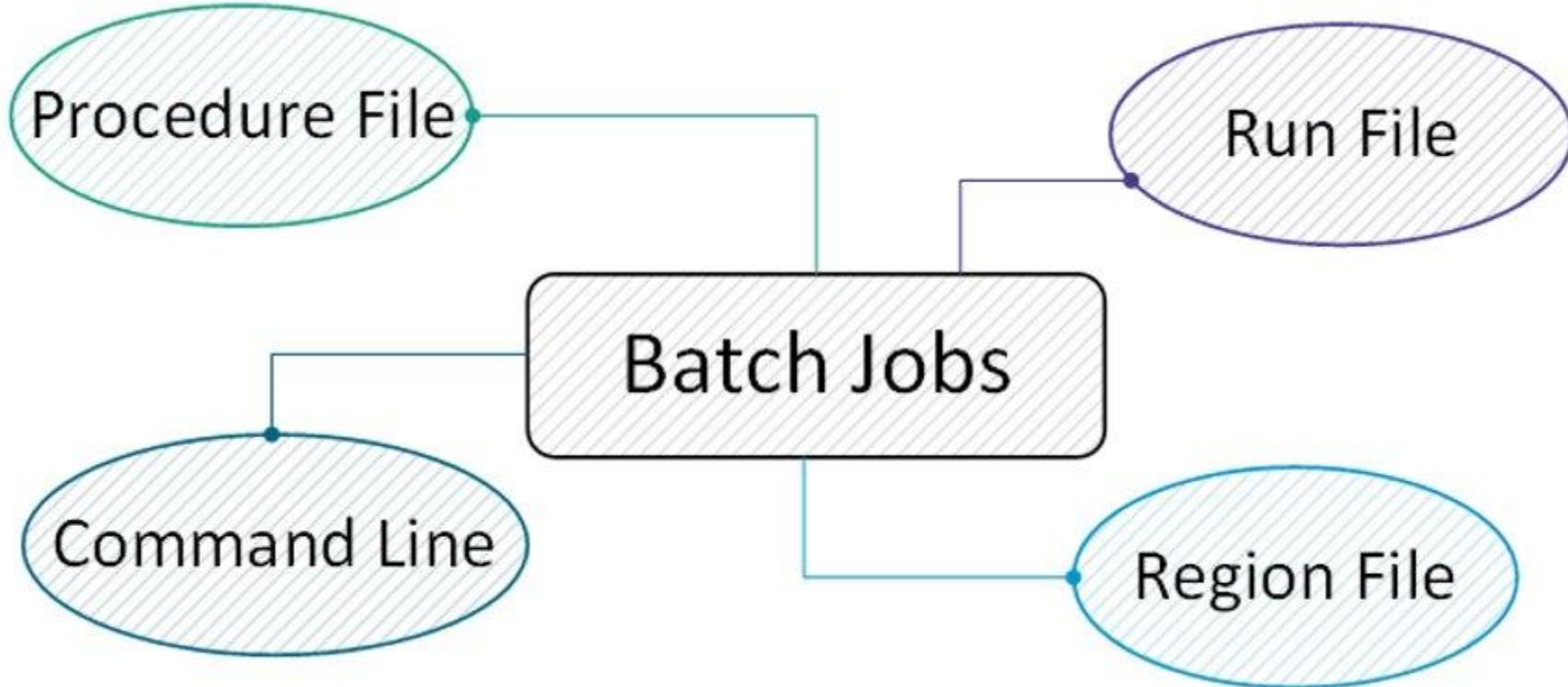
The batch is initiated via an external job scheduler on the designated job manager machine.



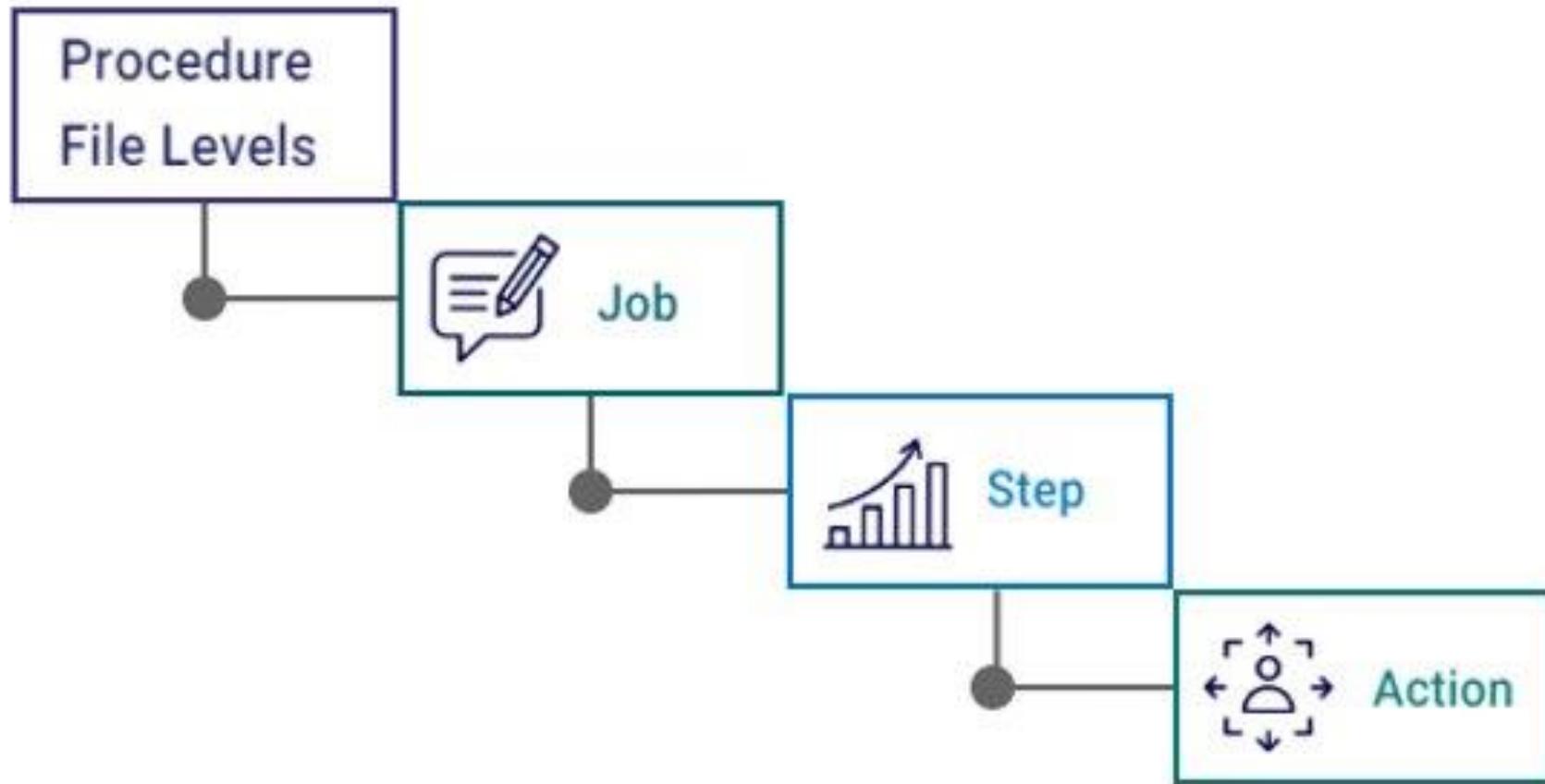
The batch executes on 1:n servers within the environment.



Core Batch Components



Procedure File



Procedure File – Contd..

Stored in System/Bin directory

Contains hierarchy of business logic

Decomposed into three levels:

- Job
 - Comprised of one or more steps.
 - Overrides at this level apply to every step and action unless subsequently overridden
- Step
 - Comprised of one or more actions.
 - Overrides at this level apply to every action within the step unless subsequently overridden.
 - Control (Bypass, Restart, Stop) is at this level
- Action
 - Work is done at this level
 - Overrides at this level apply only to this level.
 - Types include Executable, SQL, Command or Script

XML Files

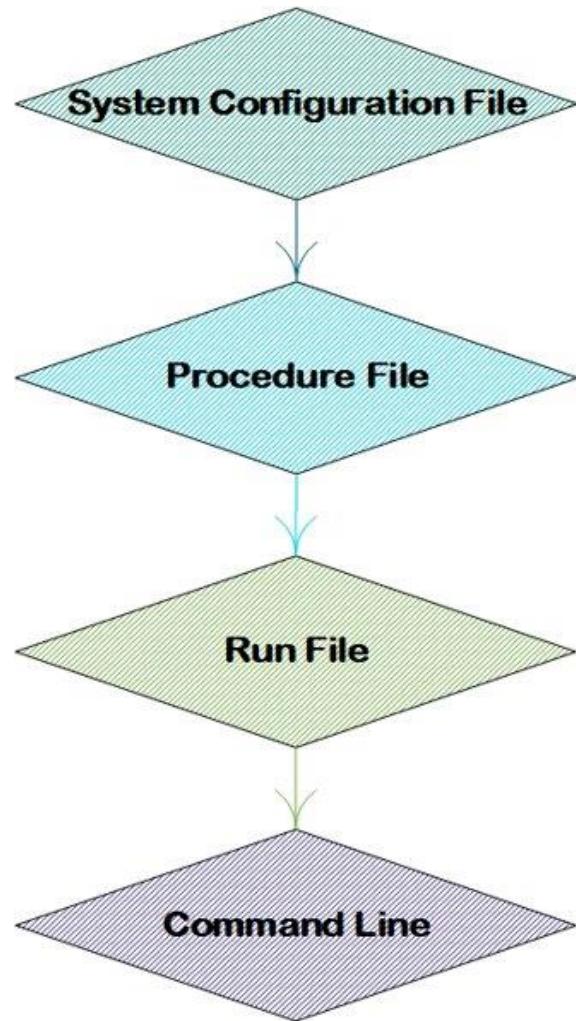
XML file naming convention:

- Er
- Prefix (xxx)
 - cer, cmc, cds, ccs, etc.
- Type
 - Proc or Run to identify which type of XML to view
- Process name (yyyy)
 - BIL0, CKMM, ELIG, etc.

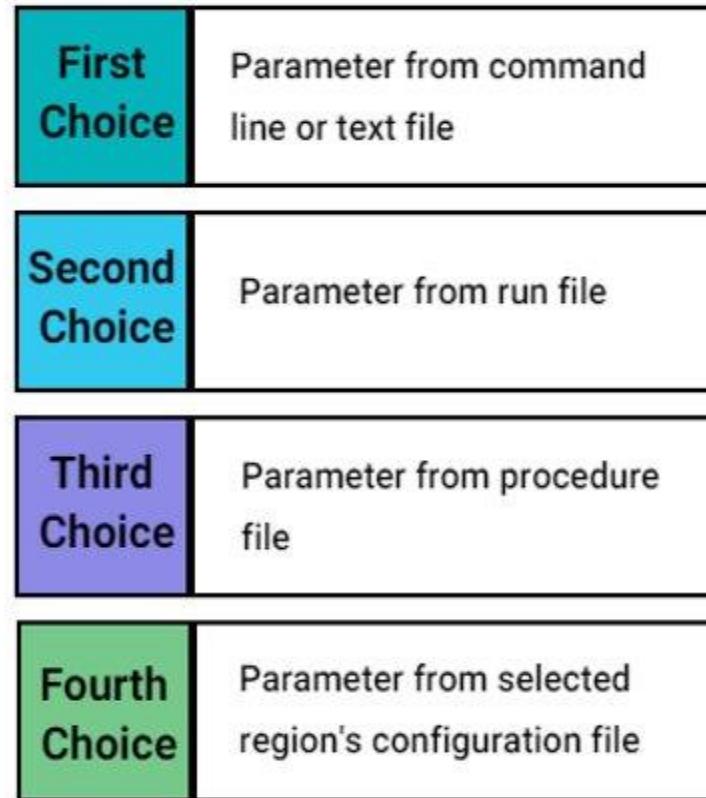
Run File, Command Line, and Region File

- Run file:
 - Allows for parameters to be set at any level
 - Points to a procedure file
- Command line:
 - Allows for parameters to be set at any level
 - Allows for control of all batches while running
- Region file:
 - Provides default values for parameters for a region

Parameter Hierarchy



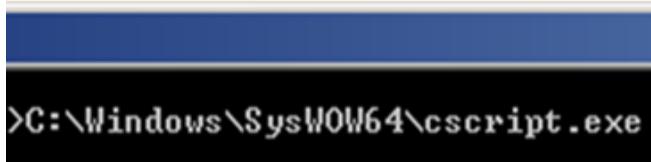
Run Time Option Hierarchy



Command Line

```
Administrator: Command Prompt  
D:\TriZetto\Facets\501\System\Bin>C:\Windows\SysWOW64\cscript.exe ErSys0FrmExecuteJob.wsf --Runbook=ErCmcElig.xml
```

Windows Script Host



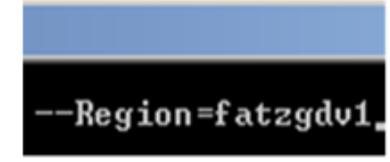
Windows Scripting File



Runbook



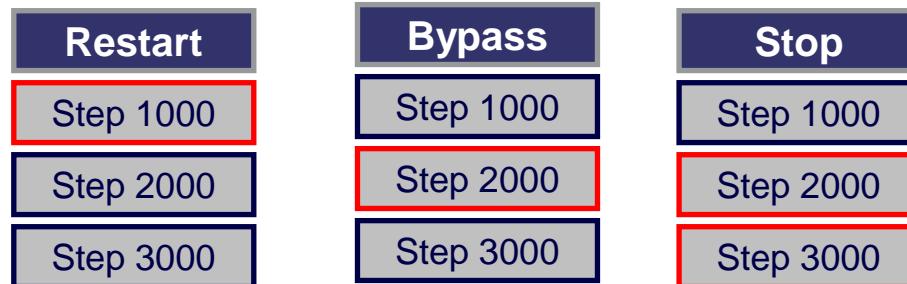
Non-Default Region



Job Directives

Job Control

- Always at the Step Level
 - Restart: Begins processing at the specified step.
 - Bypass: Bypasses the processing for the specified step(s).
 - Stop: Stops processing prior to executing the specified step.
- Example: Restart, Bypass, and Stop at Step 2000



Batch Action Type

Executable

C++ objects used for most intensive processing steps

Executes within a CerComHost###.exe process.

Distributed to any application server within the Facets Virtual Server.

1:n
CerComHost###.exe comprise a multi-engine action.

SQL

Server side logic, typically used for moving large amounts of data.

Executes within a CerComHost###.exe process although processing is done on the database server.

Script

Windows Scripting Language (VBScript) code that executes in its own process.

Typically used for lightweight logic to support the process flow of a job.

Command

DOS style commands.

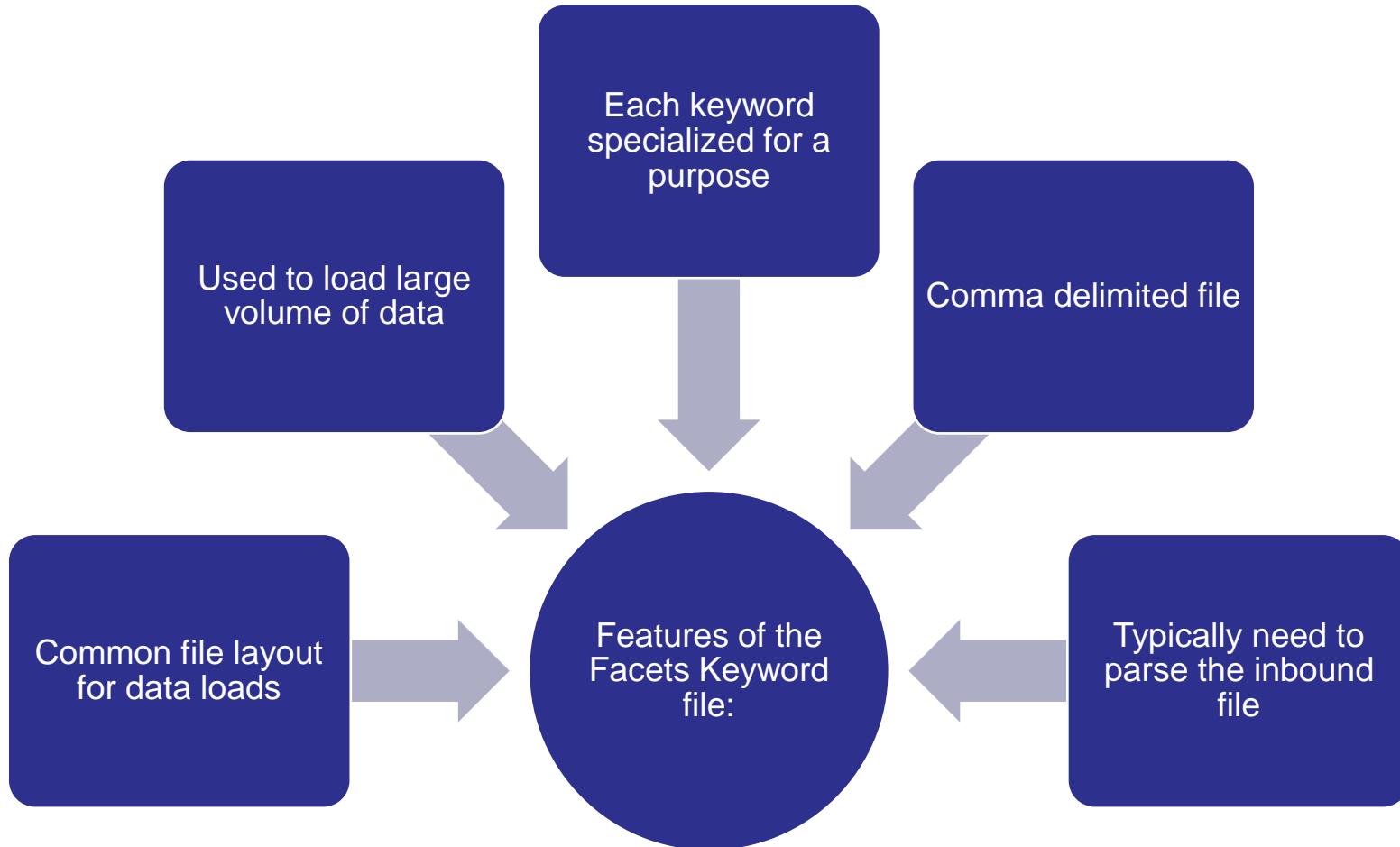
Typically used for file handling and manipulation

Batch Data Source

These data sources may utilize batch to load data to Facets:

- Data maintained outside of Facets
 - Enrollment
 - Provider Maintenance
- Data supplied by external entities
 - 3rd Party Claims
 - Medicare Enrollment and Disenrollment

Keyword File Feature



Bulk Data Load Process

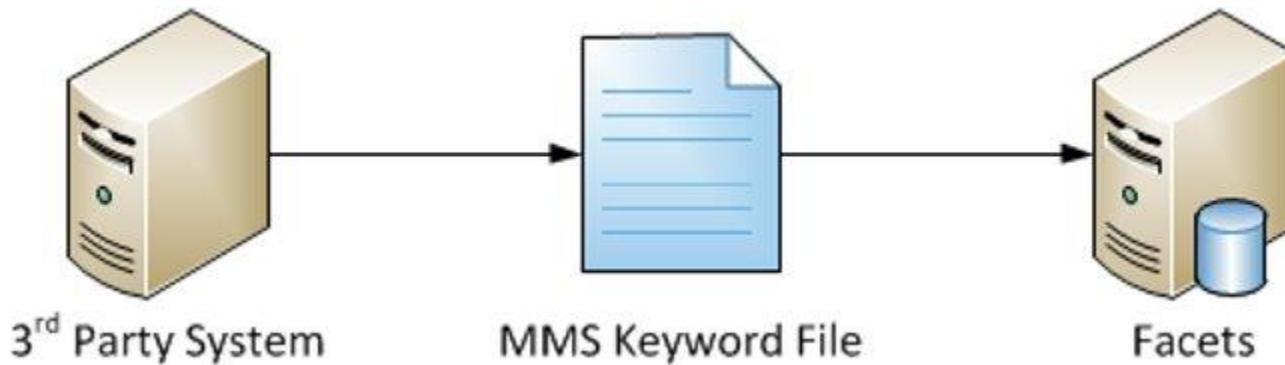
These are important Facets bulk data load processes:

- Member Maintenance
- Provider Maintenance
- Utilization Management
- Claims
- Accumulator

MMS Keyword File

Features of the MMS Keyword File:

- Comma delimited file
- Insert new or update membership records
- You typically need to parse the inbound file
- Facets Enrollment Toolkit (FET) aids creation MMS keyword files
- MMS Keyword file processed by ErCcsRunMms0

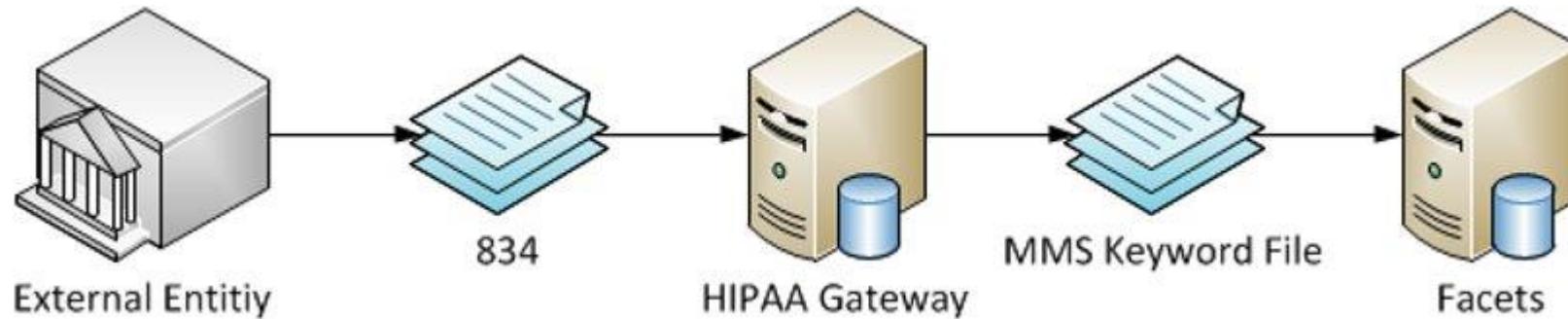


834 Transaction Set

- ErCcsRunMms0
 - Runs on Facets Application Server
 - Process the MMS keyword file
 - Communicates with HIPAA Gateway

Features of the 834 transaction set:

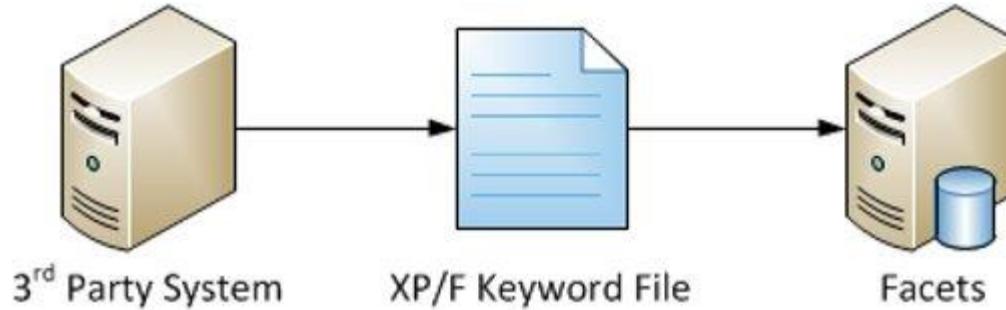
- FaFhgRunBinb
 - Runs on HIPAA Gateway
 - Parse an inbound 834 file
 - Generate a MMS keyword file



XP/F Keyword File

Features of the XP/F Keyword File:

- Comma delimited file
- Initial loading and maintenance of providers
 - Includes addresses, network affiliations, and credentialing
- You typically need to parse the inbound file
 - No standard inbound file layout
- XP/F Keyword file processed by ErCcsRunXpf0



UMI Keyword File

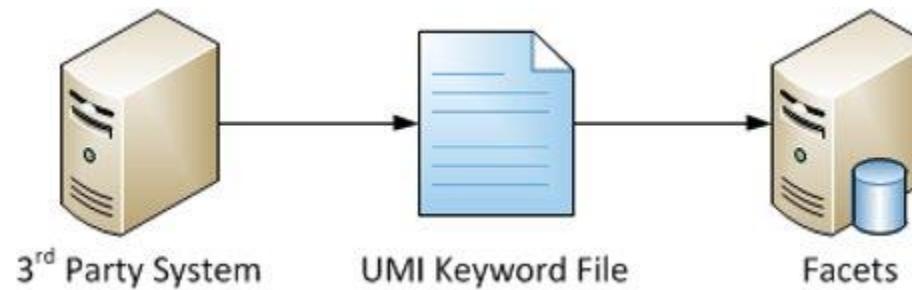
Features of the UMI Keyword File:

- Comma delimited file
- Loading referrals and pre-authorizations
 - Includes addresses, network affiliations, and credentialing

You typically need to parse the inbound file

- No standard inbound file layout
- Solutions exist to aid creation of UMI keyword files
 - e.g. UMI Solution Framework

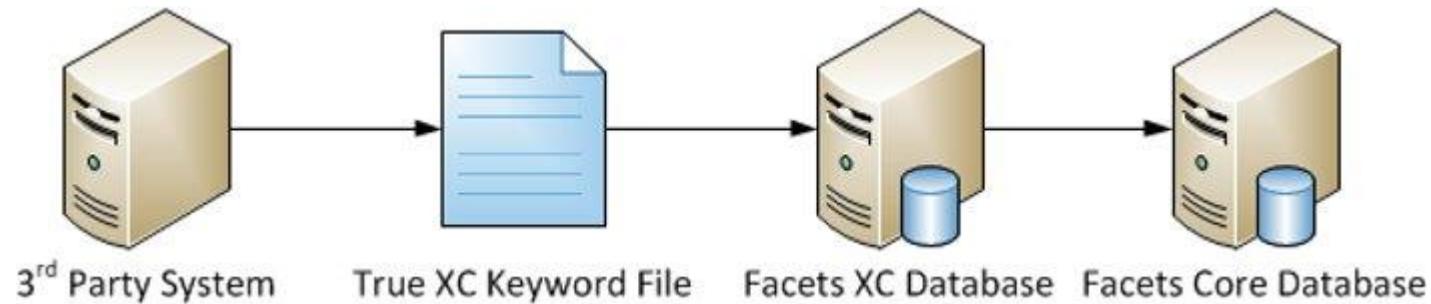
UMI Keyword file processed by ErCcsRunUmi0



True XC Keyword File

Features of the True XC Keyword File:

- Comma delimited file
- Load external claims into Facets
- Processed Claims stored in Facets XC Database
- Adjudication jobs bring claims to Facets CORE database
- True XC Keyword file processed by ErCmcRunXc00



837 Transaction set

Features of the 837 transaction set:

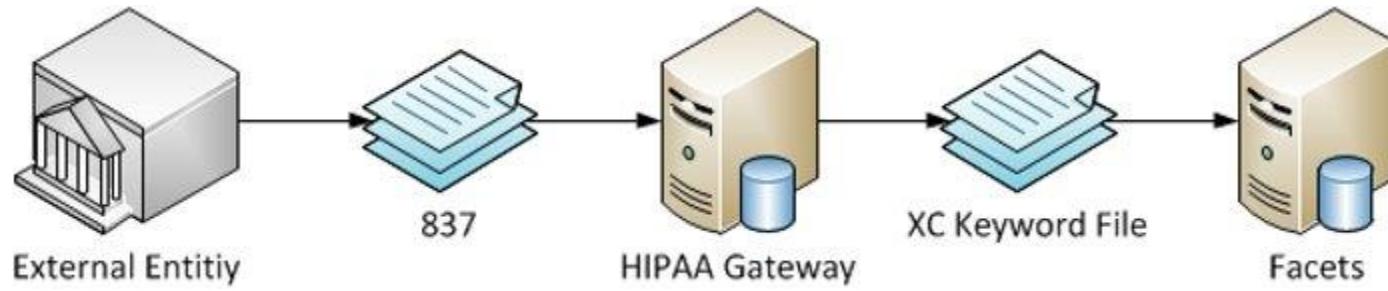
- Support for 837 using TriZetto HIPAA Gateway
- Includes two separate batch jobs:
 - FaFhgRunBinb
 - ErCcsRun837i

FaFhgRunBinb

- Runs on HIPAA Gateway
- Parse an inbound 837 file
- Generate a MMS keyword file

ErCcsRun837i

- Runs on Facets Application Server
- Process the XC keyword file
- Communicates with HIPAA Gateway



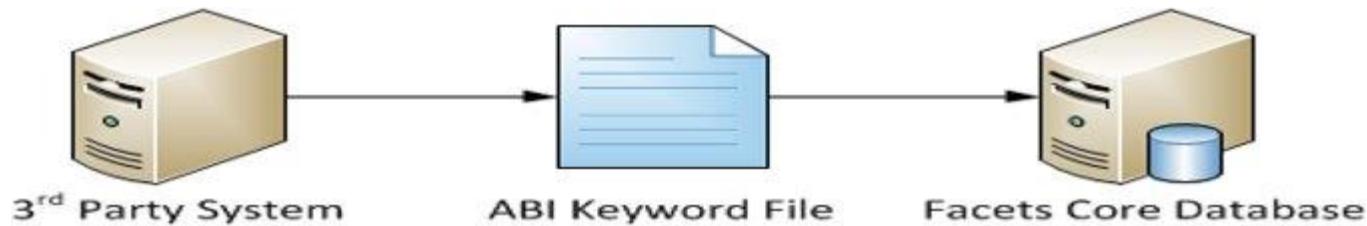
ABI Keyword File Feature

Features of the ABI Keyword File:

- Comma delimited file
- Load and updates to Member and Family Accumulator
- Typically need to parse the inbound file
 - No standard inbound file layout
 - Solutions exist to aid creation of ABI Keyword File

Adjudication jobs bring claims to Facets CORE database

ABI Keyword file processed by ErCcsRunAbix



Accumulator Export

Why export an accumulator?

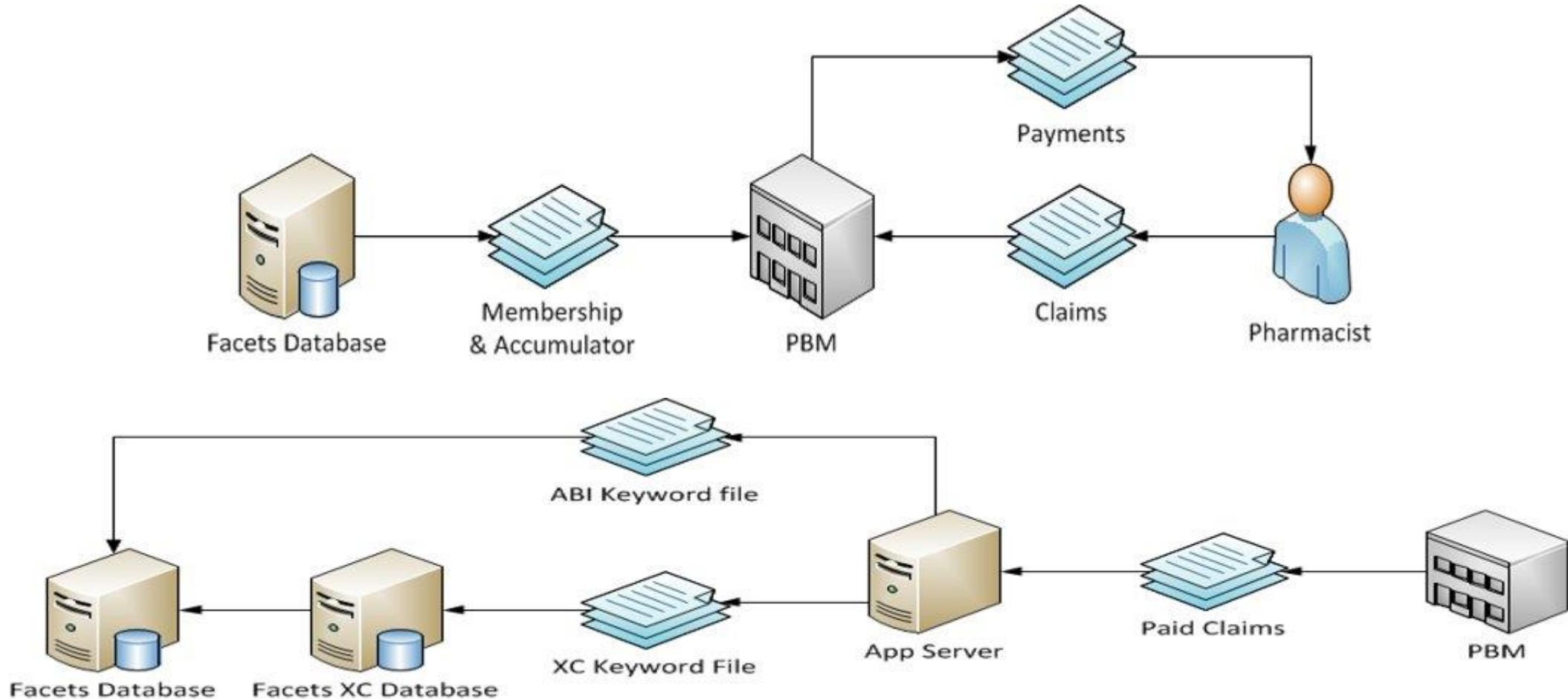
- Client has a vendor that adjudicates claims.
- Vendor needs accumulator data for adjudication.
- Vendor sends adjudicated paid claims to client.
- Client adds claims in Facets and updates accumulator.



ErCcsRunAbex produces two important files:

- Member Accumulator Extract (MATX)
- Family Accumulator Extract (FATX)

RX Claims Accumulator Example





Questions?



Thank you



Facets Accounting DM

Learning Services

Agenda

- Accounting Overview
- Claim Payment Tables
- Claims Overpayment Reduction
- Check and Accounting Tables

Accounting

Health plans make Capitation, Claim and Commission payments.

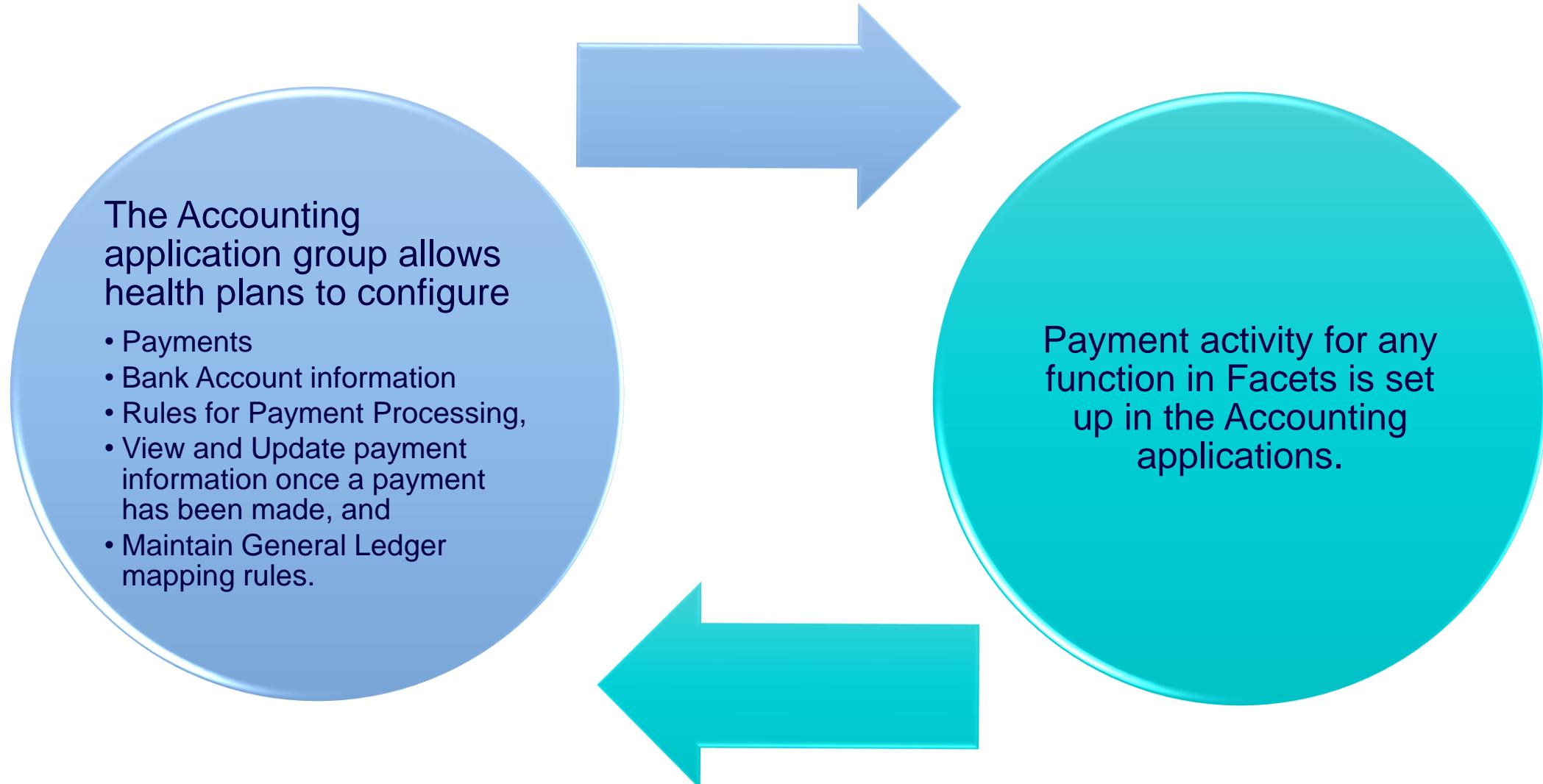


They also need to track financial information to analyze cash flow, expenses and receivables, and potential savings opportunities.

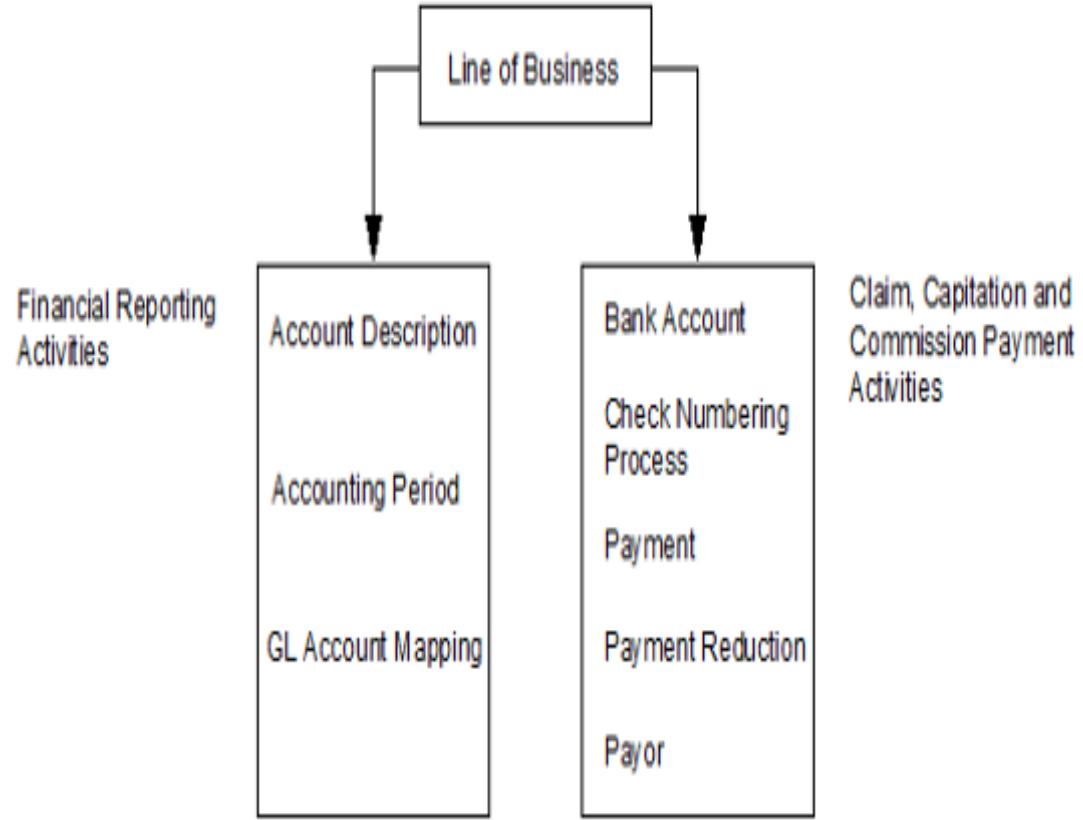
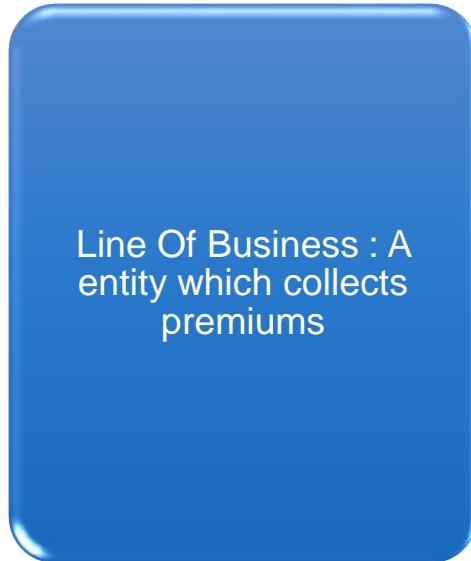


Using the Facets Accounting application group, a health plan can set up a system of accounting to create payors and lines of business that allow the health plan to make and adjust payments as well as track financial information.

Accounting - Contd..



Accounting – Contd..



Accounting – Contd..

Account Description Application

- Establishes an account number and description for the accounts for the payor and line of business.

GL Account Mapping application

- Allows you to associate a billing or commission account type and activity with a line of business, accounting category, variable data and a specific account number.

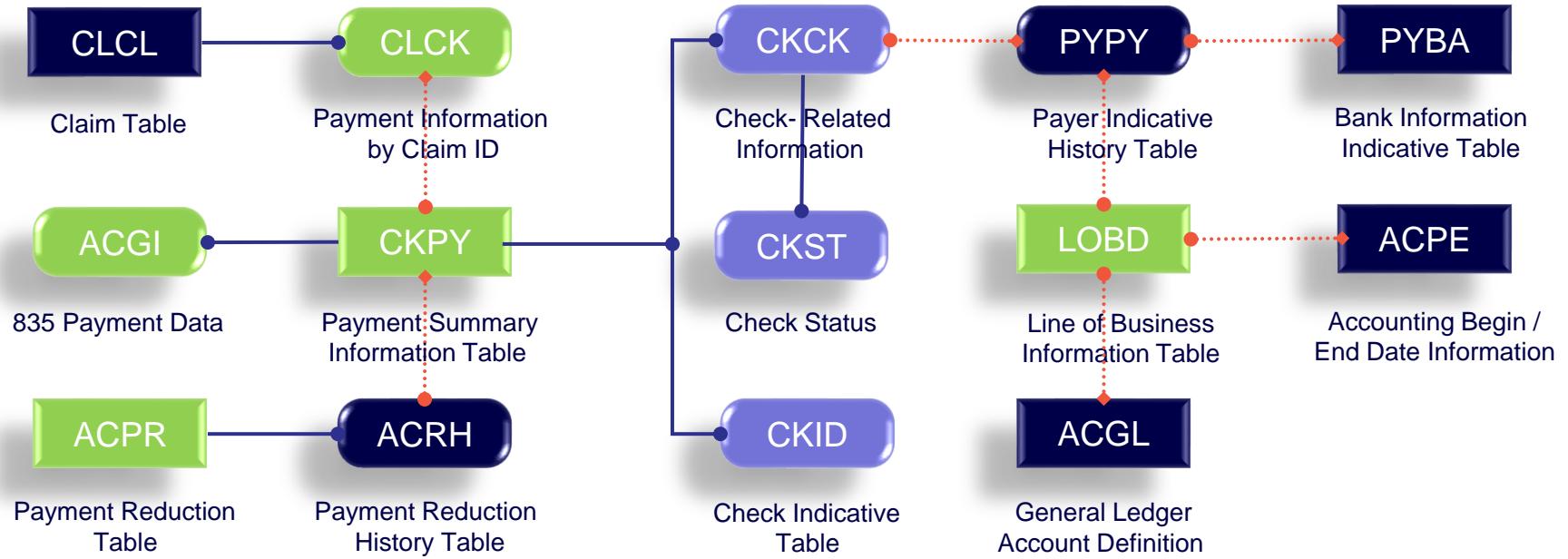
Accounting Period application

- Establish the beginning and end dates of the fiscal period of time, usually a fiscal year. If a line of business does not use fiscal periods, the beginning date and end date could span any amount of time.

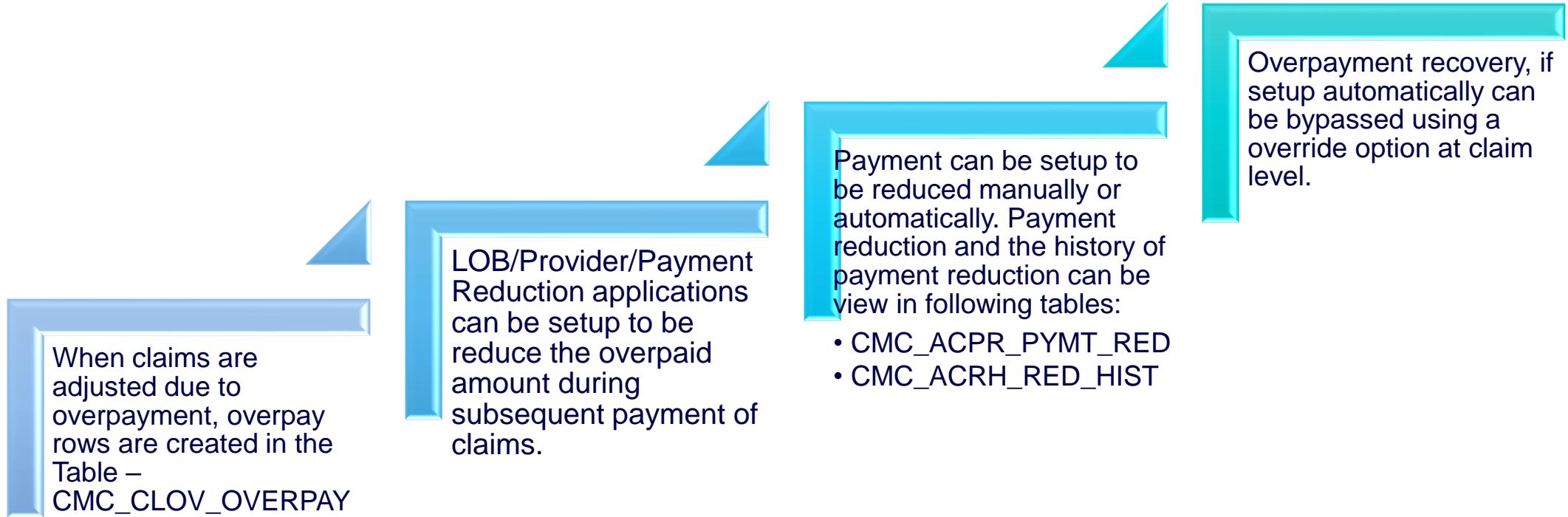
Bank Account application

- Establish the drawing bank account information for a payor that is associated with a line of business to ensure that payments are recorded to the correct account. The routing, transit and control numbers, as well as the account number, ensure that payments are recorded to the correct account.

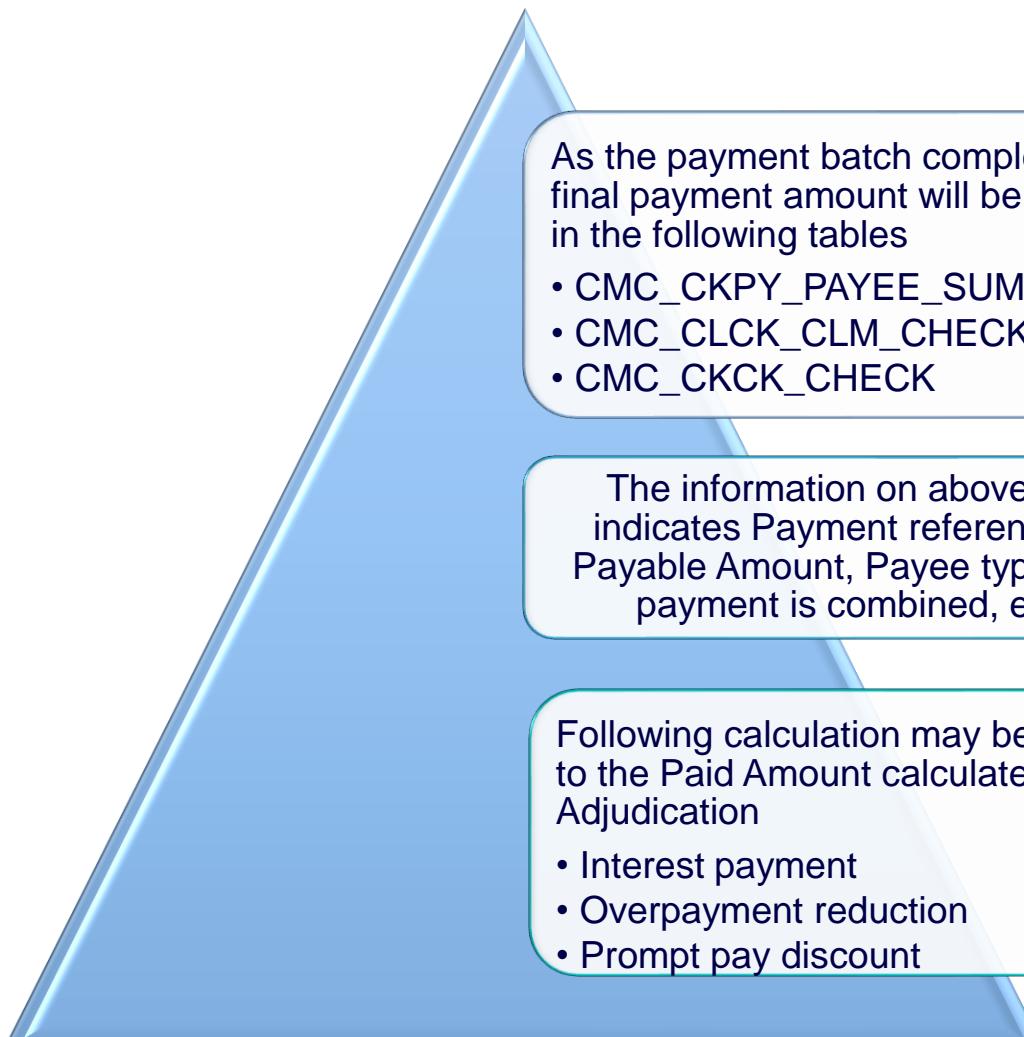
Claim Payment Tables



Claims Overpayment Reduction



Check and Accounting Tables



As the payment batch completes, the final payment amount will be created in the following tables

- CMC_CKPY_PAYEE_SUM
- CMC_CLKC_CLM_CHECK
- CMC_CKCK_CHECK

The information on above table indicates Payment reference ID , Payable Amount, Payee type, If the payment is combined, etc.,

Following calculation may be applied to the Paid Amount calculated during Adjudication

- Interest payment
- Overpayment reduction
- Prompt pay discount



Thank you



Appendix

Claim Payment Tables Contd..

Claims payment Table	Meaning
CMC_CLCK_CLM_CHECK	This table contains payment information by Claim ID. It included payee and subscriber information, as well as amount such as original and prompt payment discounts
CMC_CKPY_PAYEE_CLM	This table contains information relating to payments by payment reference id. It includes the payment source, type, date, payee, period and amount information.
CMC_CKCK_CHECK	This table contains information relating to a check. It includes payer, dates and amounts
CMC_CKST_STATUS	This table contains the status history of a check. It includes the date and user information relating to each status of the check

Claim Payment Tables Contd..

Claims payment Table	Meaning
CMC_CKID_INDIC	This table stores indicative information regarding the address and bank related to the payment
CMC_ACPR_PYMT_RED	This table maintains all payment reduction rows for a payee within a LOB. These payment reduction rows can be for overpaid medical claims, overpaid dental claims, or set up as manual reductions. If set to do so on the LOB table, these reduction rows can automatically reduce further payments.
CMC_ACRH_RED_HIST	This table maintains all of the reduction history associated with a reduction row
CMC_ACGI_PAY_HIST	This table stores historical payment data for 835 transactions
CMC_PYPY_PAYOR	This table contains indicative information relating to a payer and includes effective and termination dates as well as bank account and address information

Claim Payment Tables Contd..

Claims payment Table	Meaning
CMC_PYBA_BANK_ACCT	This table contains the bank indicative information including name, address, control, routing, transit and last check number
CMC_LOBD_LINE_BUS	This table stores information pertaining to the user's defined line of business
CMC_ACPE_PER_DTS	This table stores the beginning and end dates for a user defined accounting period

Underpayment

CLCL

<u>Claim Id</u>	<u>Status</u>	<u>Paid Amt</u>	<u>Claim ID Adjusted To / From</u>
111111111100	01, 02, 91	\$50	To: 111111111101
111111111101	01, 02	\$100	From: 111111111100

CDML

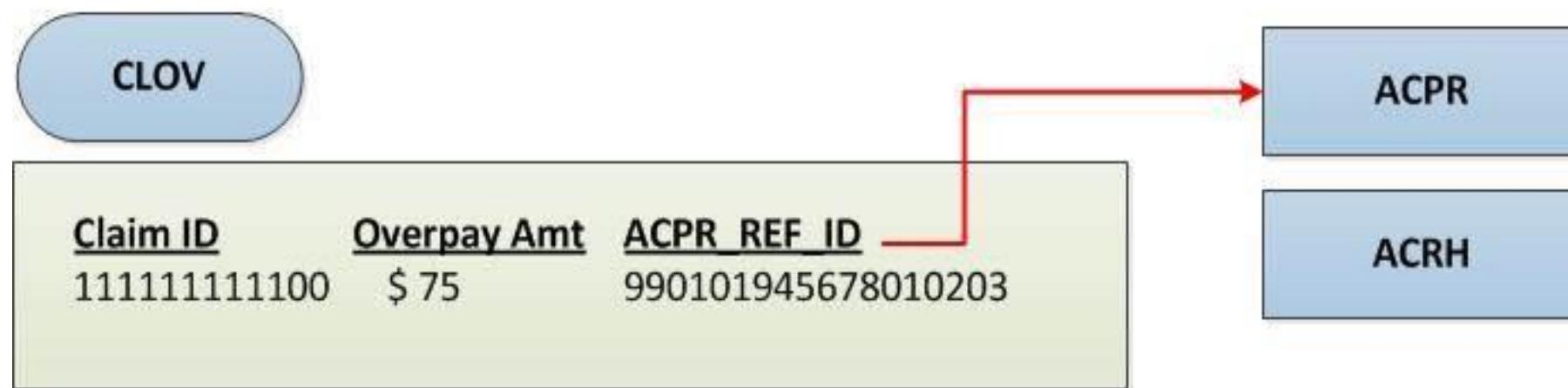
<u>Claim Id</u>	<u>Line</u>	<u>Status</u>	<u>Paid Amt</u>
111111111100	1	01, 02, 91	\$25
111111111100	2	01, 02, 91	\$25
<hr/>			
111111111101	1	01, 02	\$75
111111111101	2	01, 02	\$25

CLST

<u>Claim Id</u>	<u>Status</u>
111111111100	01
111111111100	02
111111111100	91
<hr/>	
111111111101	01
111111111101	02

Overpayment – Contd..

CLCL			
<u>Claim ID</u>	<u>Status</u>	<u>Paid Amt</u>	<u>Claim ID Adj To / From</u>
111111111100	01, 02, 91	\$100	To: 111111111101
111111111101	01, 02	\$25	From: 111111111100



Tables

Payment Summary Info Table

CMC_CLCK_CLM_CHECK	
	<u>CLCL ID</u>
	<u>CLK PAYEE IND</u>
	<u>LOBD ID</u>
	CKPY_REF_ID*
	CKPY_PAY_DT*
	PRPR_ID*
	MEME_CK*
	SBSB_CK*
	CLK_PAYEE_PR_ID
	CLK_COMB_IND*
	CLK_ORIG_AMT*
	CLK_EOB_IND
	CLK_NTWK_IND
	CLK_NET_AMT*
	CLCL_CL_TYPE*

Payment Reduction Table

CMC_ACPR_PYMT_RED	
	<u>ACPR REF ID</u>
	<u>ACPR SUB TYPE</u>
	ACPR_TX_YR*
	ACPR_TYPE*
	ACPR_CREATE_DT*
	LOBD_ID*
	ACPR_PAYEE_PR_ID
	ACPR_PAYEE_CK
	ACPR_PAYEE_TYPE*
	ACPR_PYMT_TYPE*
	ACPR_COMB_IND*
	ACPR_PER_END_DT*
	ACPR_ORIG_AMT*
	ACPR_DEDUCT_AMT*
	ACPR_NET_AMT*
	ACPR_STS*
	EXCD_ID

CMC_CKPY_PAYEE_SUM	
	<u>CKPY REF ID</u>
	CKPY_TYPE*
	CKPY_PAY_DT*
	LOBD_ID*
	CKPY_PAYEE_PR_ID
	CKPY_PAYEE_CK
	CKPY_PAYEE_TYPE*
	CKPY_PYMT_TYPE*
	CKPY_COMB_IND*
	CKPY_PER_END_DT*
	CKPY_ORIG_AMT*
	CKPY_DEDUCT_AMT*
	CKPY_NET_AMT*
	CKPY_CURR_CKCK_SEQ

Payment Information by Claim ID Table



Facets Claims Processing

Learning Services

Agenda

- Claims Processing in Facets
- Medical Claims Entry
- Claims Flow
- Overrides

Claim Processing

Different application for Medical, Hospital, Dental, Disability, Vision etc..

Claims Inquiry application provides a broad view of claims and related information. No processing is done in this except Adding Notes

Claim Pre-pricing application are used for entering claims data and get an estimate of pricing/payment values. Not actually adjudicates

Claim Processing application is where actual Claims adjudication process takes place



Medical Claim Processing

Medical Claim Processing

To enter details of Professional Claims, use Medical Claims Processing application

To enter details of Hospital Claims, use Hospital Claims Processing. Facility can be used as Providers for Hospital Claims.

Claim Information

- Claim has subscriber, Provider and Diagnosis details in Indicative Page.
- Depending on entered data, Facets may throw error or warning message.
- While Error messages prevents claims from processing, warning message can be ignored and claims can be accepted.

Subscriber cannot be changed once claim is saved.

Line Level Information

- Line Item tab has all details such as Payment prefix, Different Amounts calculated, Network status and UM Status
- Pricing tab shows Agreement and Pricing.

Medical Claims Processing – Contd..

Line Level Information

- Limit accums calculation are displayed in separate tab.
- View menu has different option like viewing “Product and Prefixes”, “Claim Flow”, Accums, etc...
- Price Calculation tab shows Service Rule, Agreement and Pricing.
- Accumulated Limit values are displayed in Accum Limits tab.

COB – Applies COB Information if applicable.

The Other Carrier fields in this dialog box include fields that are used to store other carrier amounts. With the exception of the Other Carrier Sanction amount, these fields are used for reporting purposes only.

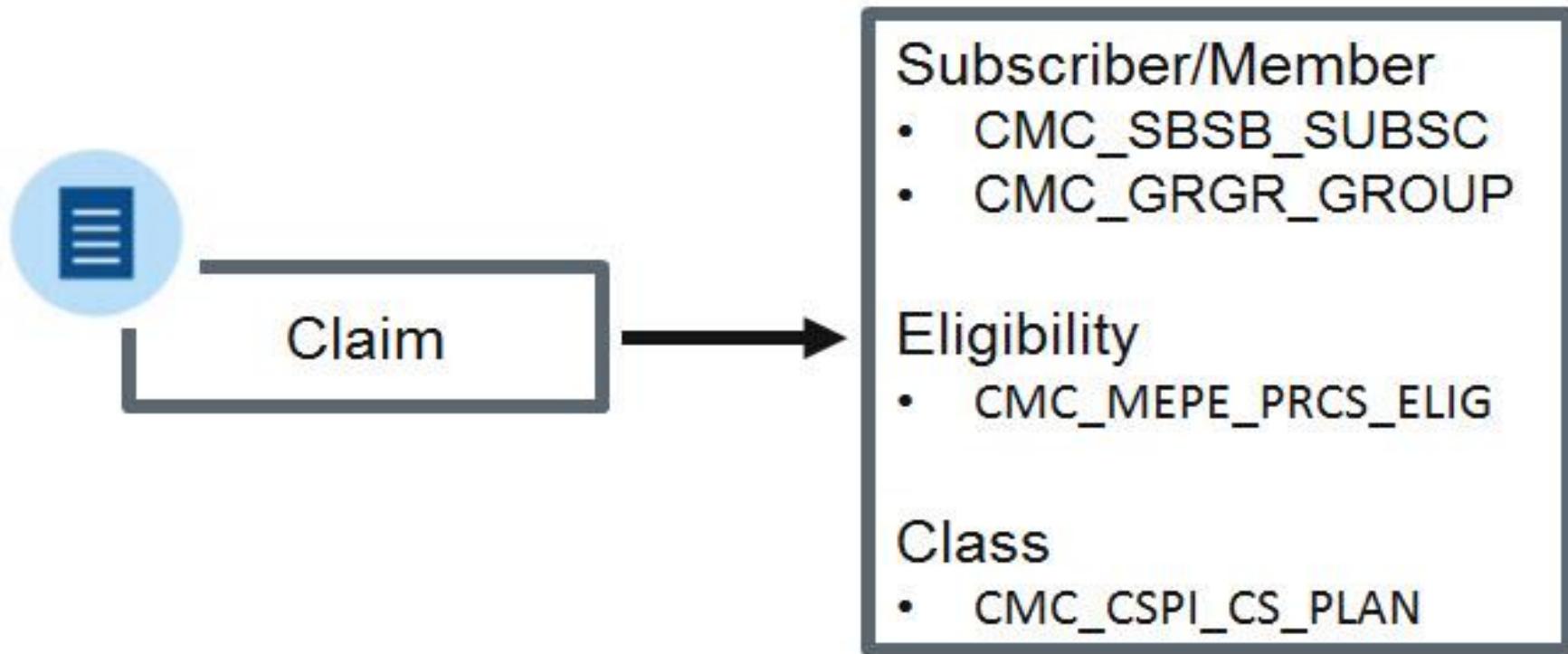
Overrides – Can be applied at Claim and/or Line Level. Each override should be provided with a Explanation code.

Adjustments

- Only Finalized claims can be adjusted.
- Adjustments can be for variety of reasons like overpay, underpay, re-adjudication etc..
- When a claim is adjusted, the current claim row is voided (moved to 91 status) and new segment of same claim is created.

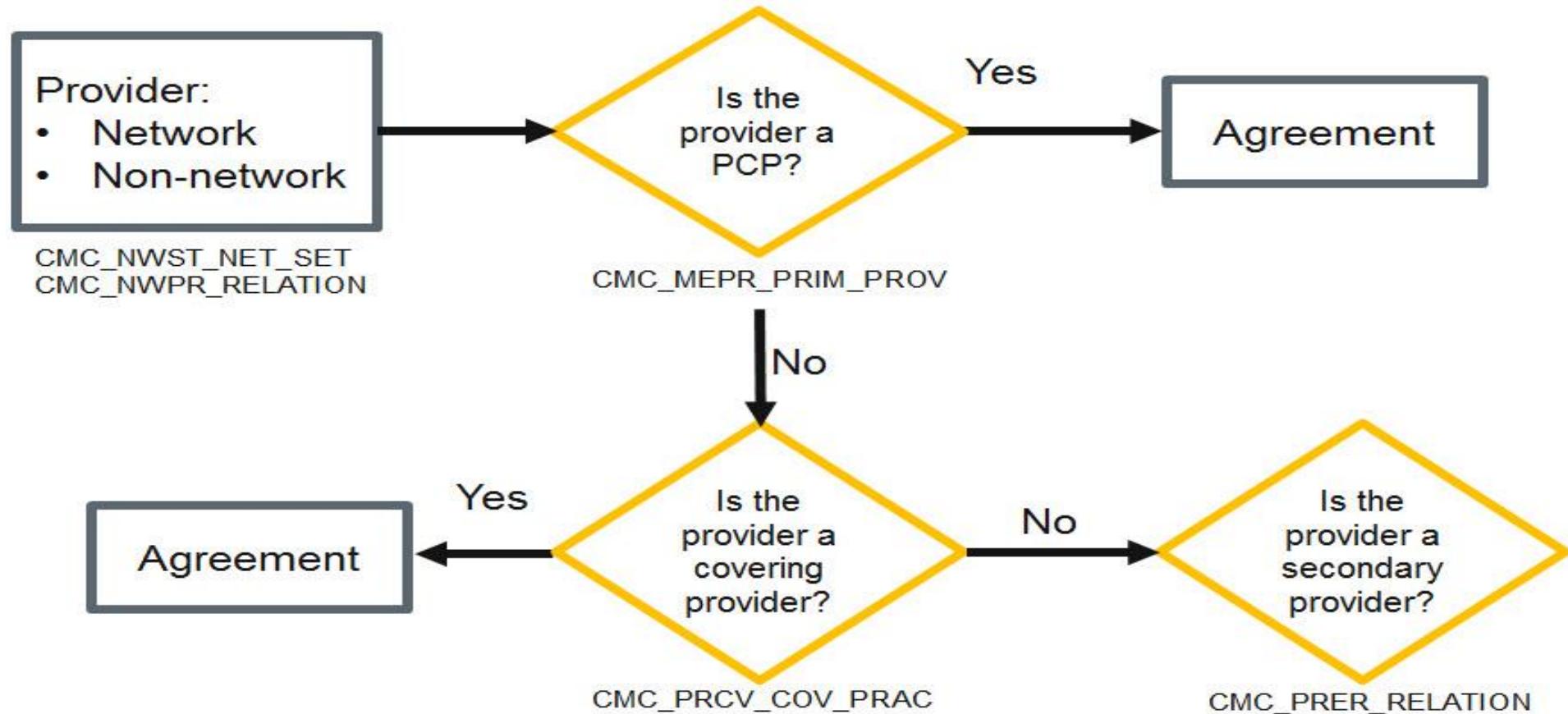
Medical Claims Processing – Contd..

Step 1 - Eligibility



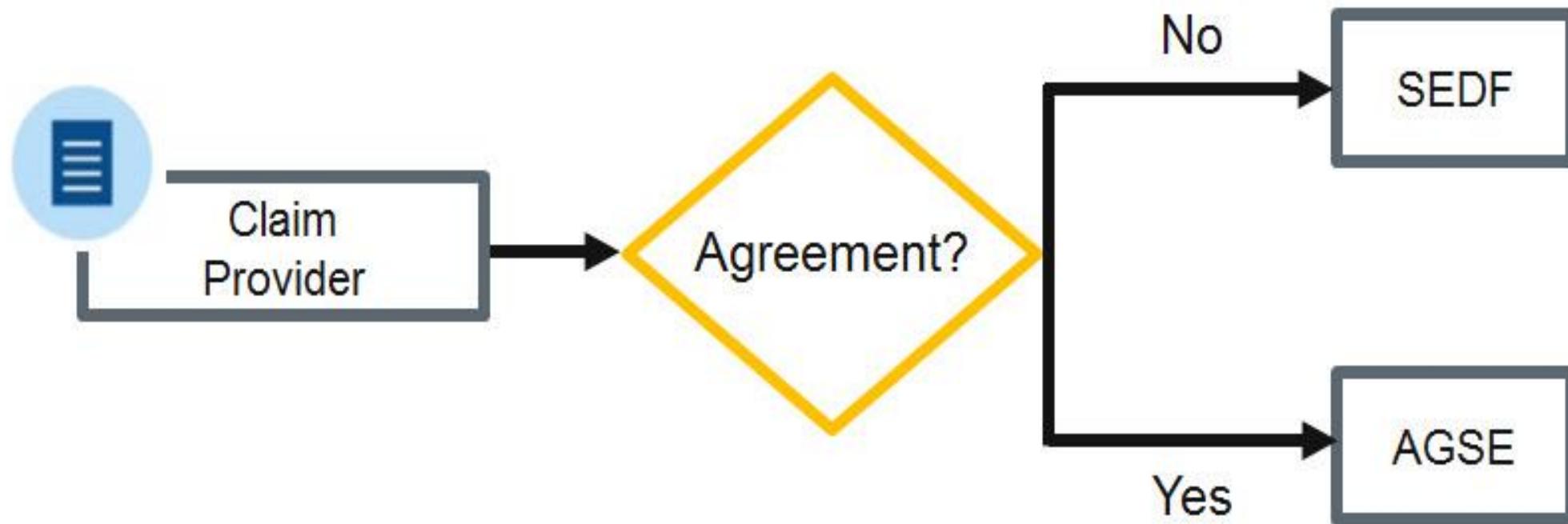
Medical Claims Processing – Contd..

Step 2 - Provider/Network Determination



Medical Claims Processing – Contd..

Step 3 – Service Definition



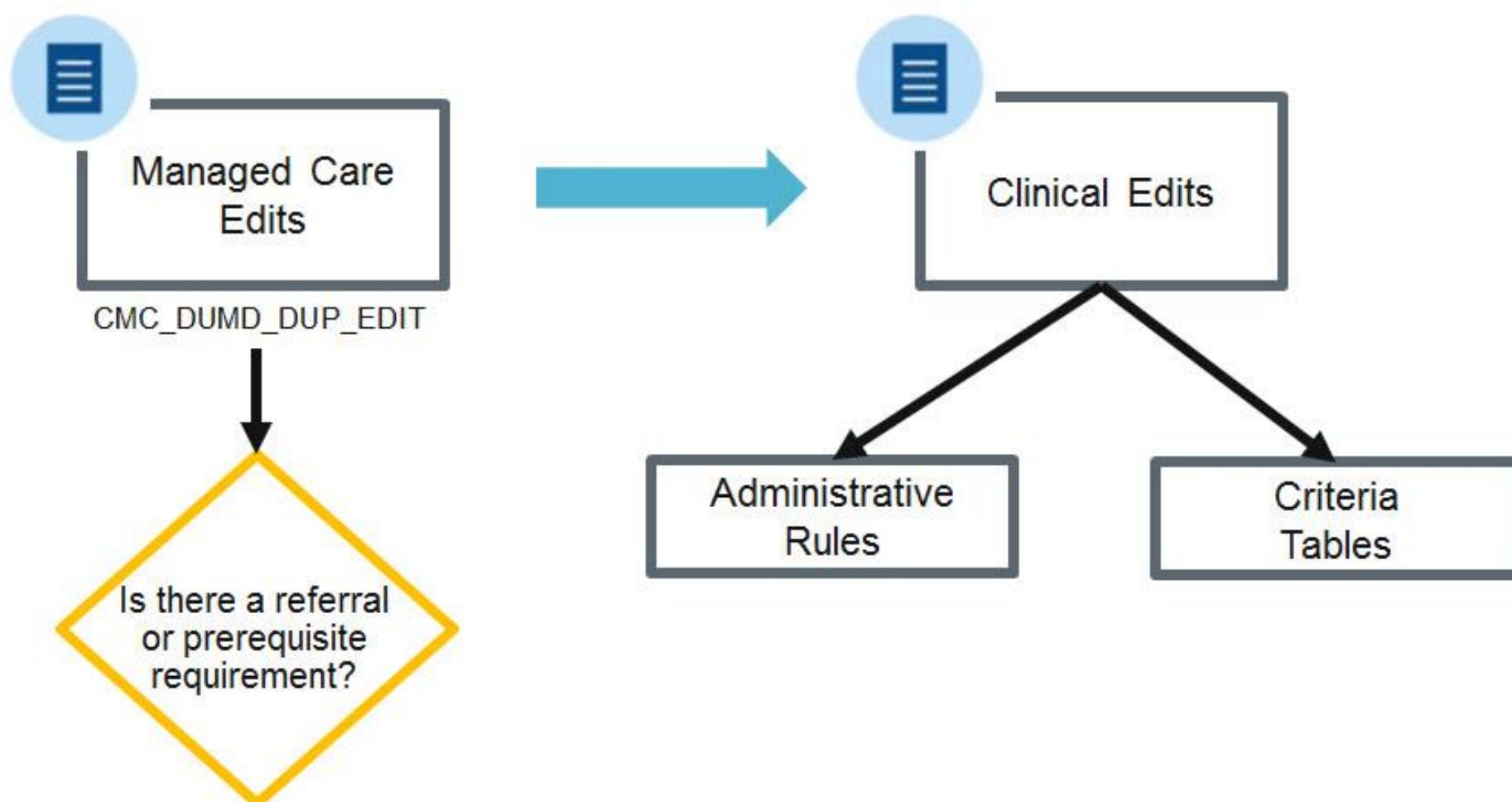
Medical Claims Processing – Contd..

Step 4 and 5

- In step four, charge roll ups (CMC_SEPC_PRICE):
 - All inclusive per diem
 - All inclusive per case
 - DRG pricing types
- In step five, duplicate editing/claims history check

Medical Claims Processing – Contd..

Step 6 and 7



Medical Claims Processing – Contd..

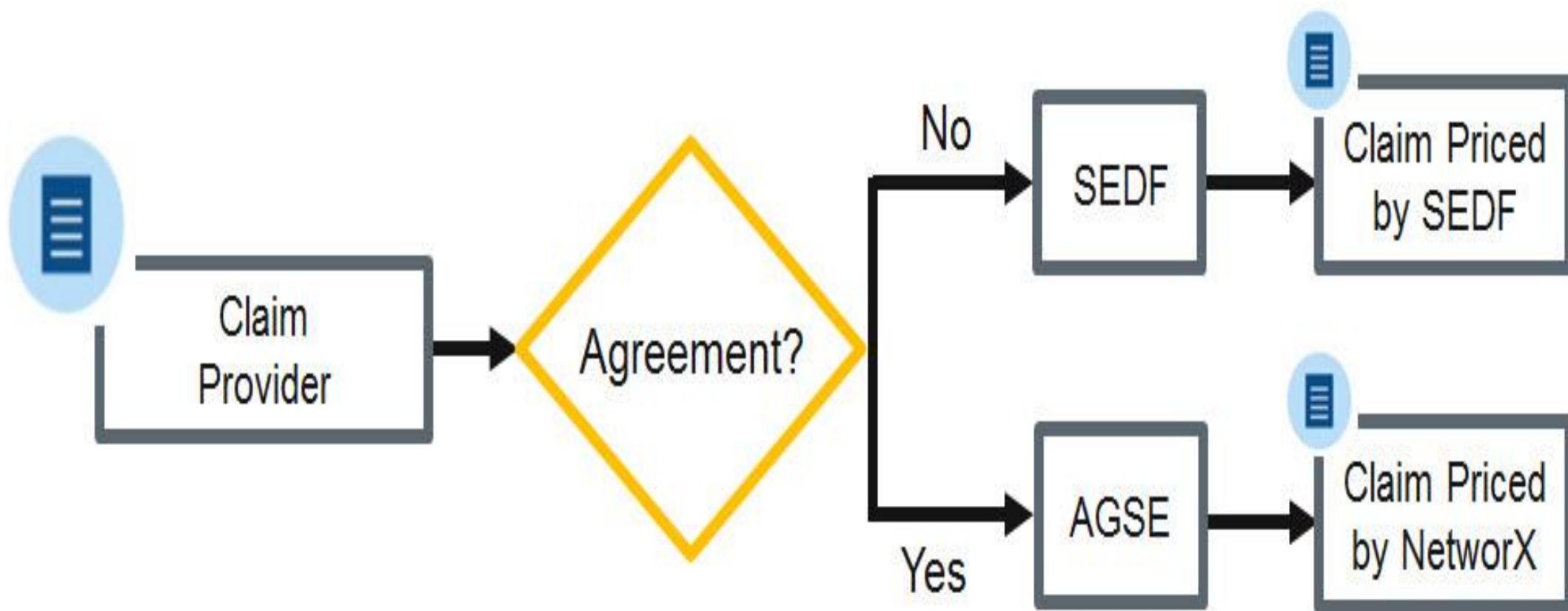
Step 8 – Line Item Prefixes

In step eight, line item prefixes populated

CMC_CDML_CL_LINE
CMC_CDDL_CL_LINE

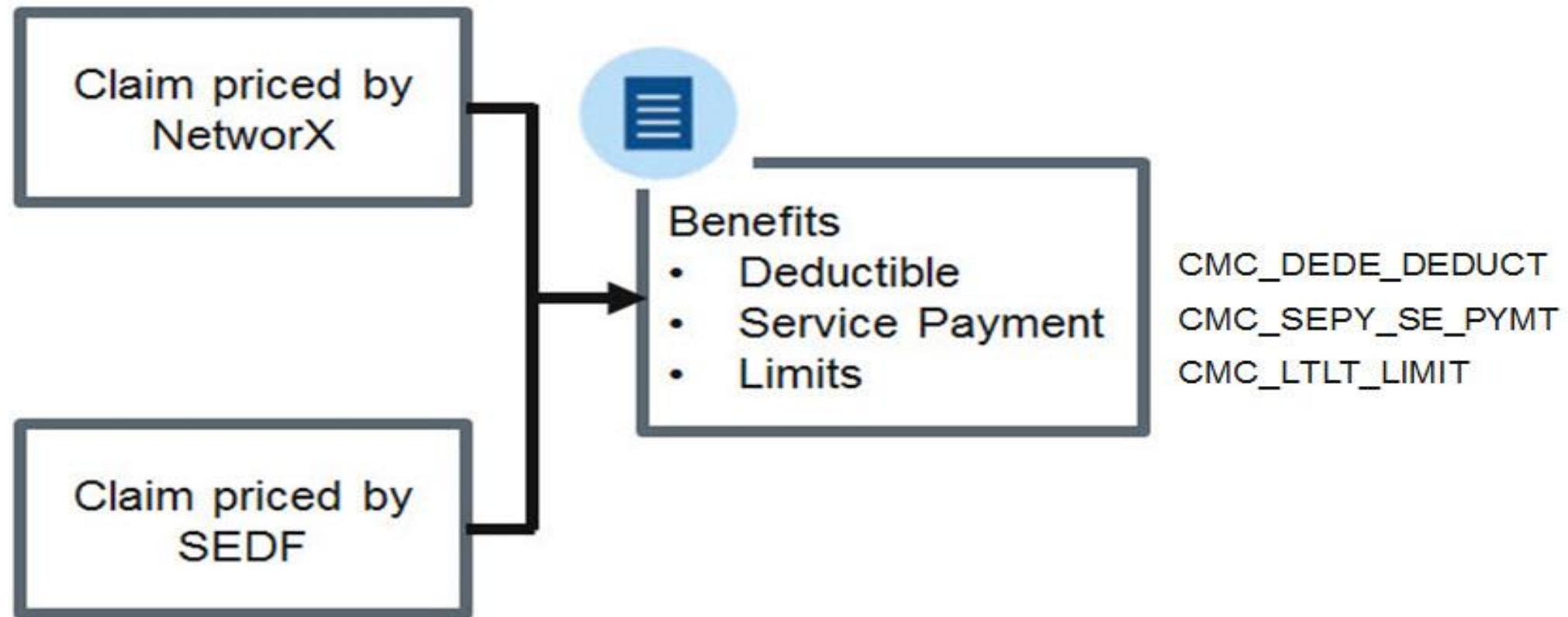
Medical Claims Processing – Contd..

Step 9 – Pricing



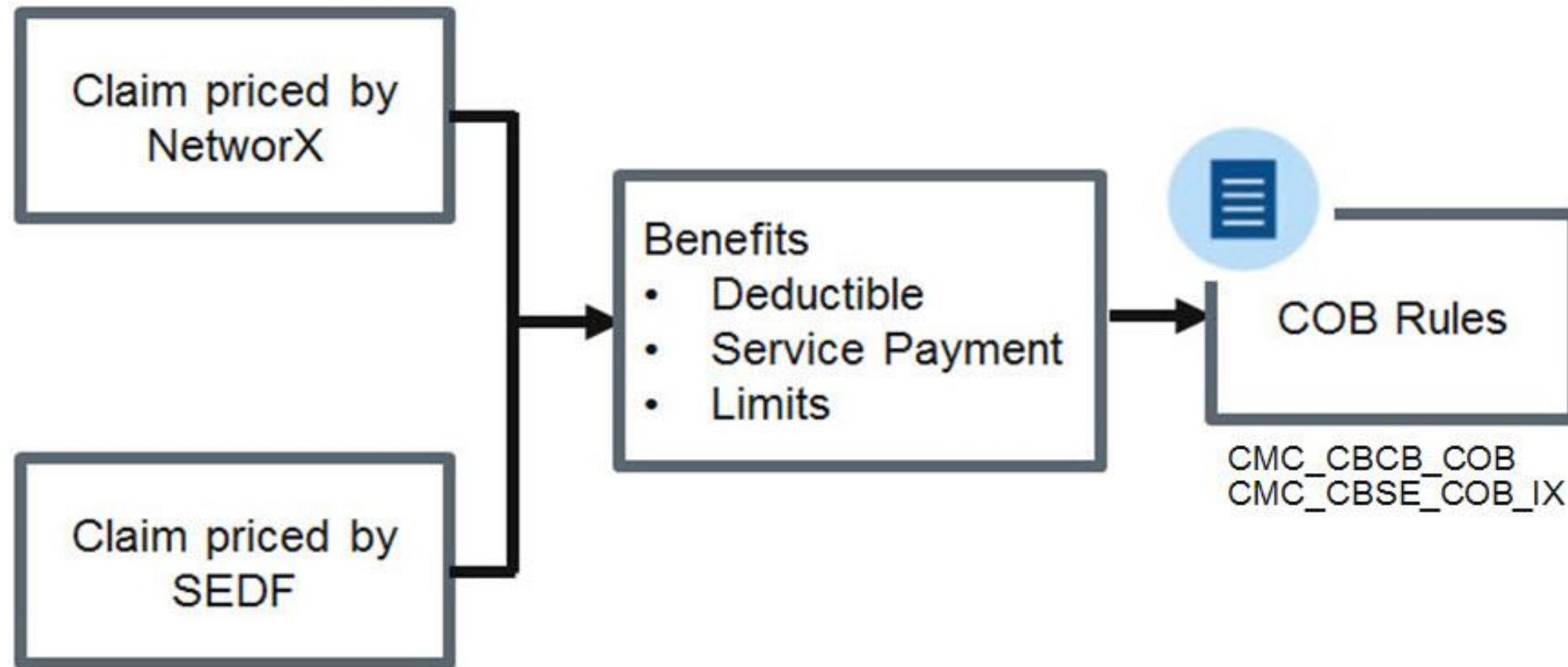
Medical Claims Processing – Contd..

Step 10 – Service Payment Routine



Medical Claims Processing – Contd..

Step 11 - COB



Medical Claims Processing – Contd..

Steps 12 & 13

In step 12, there is payment drag

CMC_AIAI_ADMIN_INFO

CMC_AGAG AGREEMENT

In step 13, update accumulators

CMC_EBCL_EOB_DATE

CMC_MATX_ACCUM_TXN

CMC_FATX_ACCUM_TXN

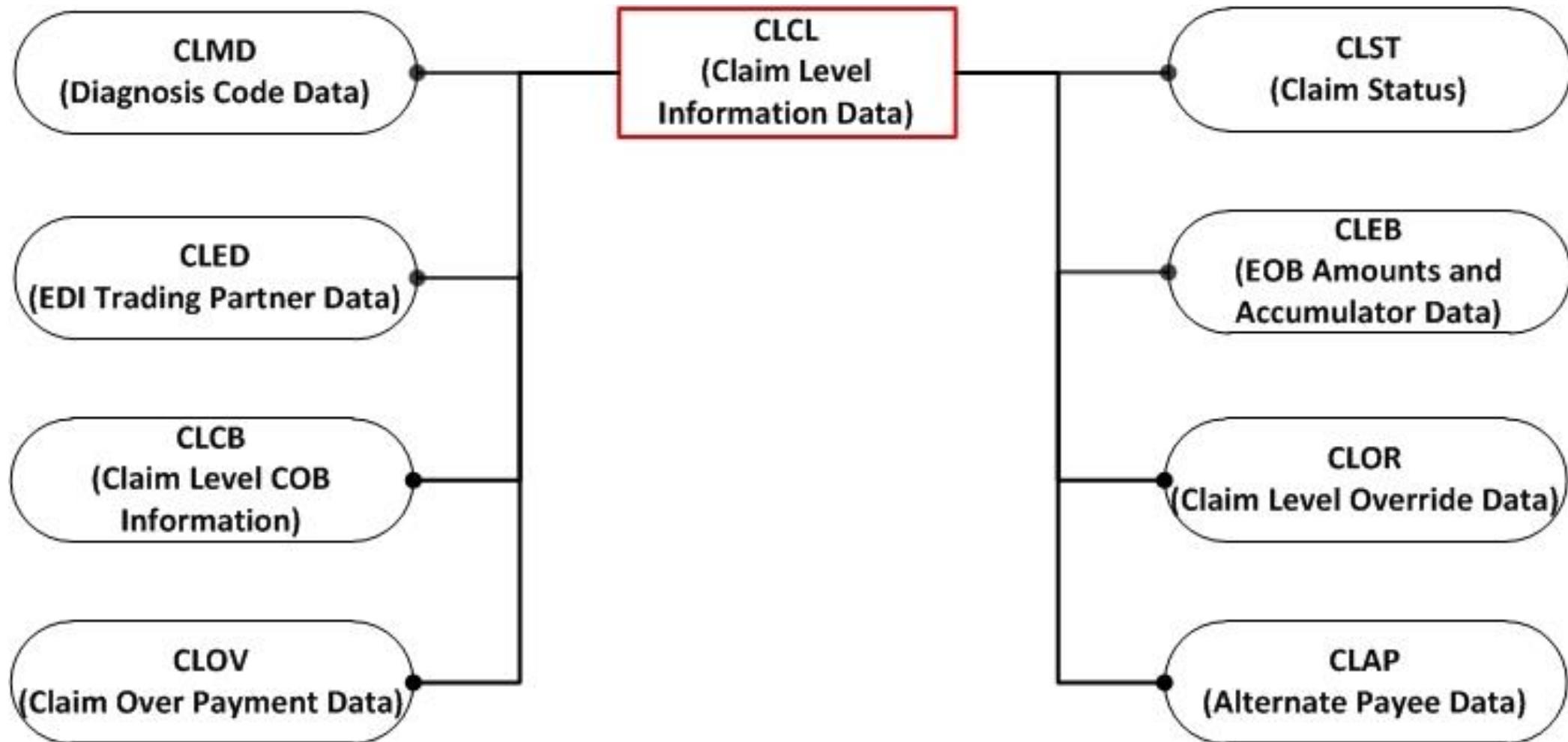
Medical Claims Processing – Contd..

Steps 14

In step 14, update claim status

- 01 – Claim awaiting batch
- 15 – Claim pends with error

Claim Summary Tables



Claims Status

A claim goes through different status during processing

- 01 – Accepted – When a claim is successfully adjudicated
- 11/15 – Pended – When a claim is pended and is waiting for a user to correct error and/or release pend.
- 02 – Paid/Finalized – When a claim is finalized and payment is completed
- 91 – Adjusted – When a paid claim is adjusted. A claim can go to 91 status only from 02 status.
- 99 – Closed – When the claim is closed and no further action can be taken.

There are other claims status as well for Encounters, Pre-priced etc..

UM Requirement

UM Match is done based on Procedure UM Definition, Product or provider level set up of Pre-Auth and Referral requirements.

Services review will be matched for Professional Claims. confinement review will be matched for Inpatient Hospital Claims

When the Member has No UM History, Facets displays Claim Warning Messages to indicate that referral or pre-authorization violations exist and that no matches were found, and Facets disables the Match UM Action menu option and button

If there are multiple matches or non matching UM history for member, UM Matching can be done manually using 'Match UM' option.

Claims Flow

The Claim Adjudication Routine include following functionality

- Eligibility
- Service Conversion
- Provider Network Determination
- Service Definition (AGSE or SEDF)
- Charge roll-up (if applicable)
- Duplicate Editing/Claims History check
- UM Requirement check
- Clinical Editing (iCES, ClaimCheck)
- Line Item Prefixes (product components)
- Pricing

Claims Payment batch follows Claim Adjudication to finalize claims.



Claims Payment

Claims Payment

During the payment batch, Facets process and create payments and transactions

Facets assigns a Payment Reference ID to all payments.

(Electronic Fund Transfers), the Accounting applications enable health plans to configure the payors, bank accounts and lines of business to generate the de-normalized (pre-formatted) data required



Questions?



Thank you

Appendix

Claims Table

Claims Summary Table

CMC_CLCL_CLAIM	
	CLCL_ID
	MEME_CK*
	GRGR_CK*
	SBSB_CK*
	SGSG_CK*
	PRPR_ID*
	CLCL_CL_TYPE*
	CLCL_CL_SUB_TYPE*
	CLCL_CUR_STS*
	CLCL_SITE*
	CLCL_LAST_ACT_DTM*
	CLCL_INPUT_DT*
	CLCL_RECV_DT*
	CLCL_ACPT_DTM*
	CLCL_LOW_SVC_DT*
	CLCL_HIGH_SVC_DT*
	CSPD_CAT*
	CSCS_ID*
	CSPI_ID*
	PDPD_ID*
	MEPE_FI*
	MEPE_PLAN_ENTRY_DT*
	CLCL_COBRA_IND*
	CLCL_ME_AGE*
	MEME_REL*
	MEME_SEX*
	MEME_RECORD_NO*
	PDBC_PFX_SEDF*

Claim Line Item Details Table

CMC_CDML_CL_LINE	
	CLCL_ID
	CDML_SEQ_NO
	MEME_CK*
	PRPR_ID*
	LOBD_ID*
	PDVC_LOBD_PTR*
	CDML_CUR_STS*
	SEPC_PRICE_ID*
	SESE_ID*
	SESE_RULE*
	PSCD_ID*
	IDCD_ID*
	IDCD_ID_REL*
	CDML_FROM_DT*
	CDML_TO_DT*
	CDML_CHG_AMT*
	CDML_CONSIDER_CHG*
	CDML_ALLOW*
	CDML_UNITS_ALLOW*
	CDML_DED_AMT*
	CDML_COPAY_AMT*
	CDML_COINS_AMT*
	CDML_AG_PRICE*
	CDML_CL_NTWK_IND*

Medical Claim Diagnosis Table

Claim ID 133080000101	Provider ID V13PROV101	Status 02 Accepted; Batch Complete	Next Rev Date Unassigned	Payee Provider	Notes Exist
Subscriber ID 131000099		Suffix 00	Member	Subscriber - Pendleton,Zachary <input checked="" type="checkbox"/>	
Subscriber Notes Exist			Member Notes Exist		
Provider ID V13PROV101		Remit Info		Received Date	10/24/2013
Diagnosis Codes					
1	R109	4		7	
2		5		8	
3		6		9	
10		11		12	
R109 Unspecified abdominal pain					
ICD Version:		Input: ICD-10		Processed: ICD - 10	

CMC_CLMD_DIAG	
	CLCL ID
	CLMD TYPE
	MEME_CK*
	IDCD_ID
	CLMD_POA_IND
	IDCD_ID_SUB*
	IDCD_ID_TRANS



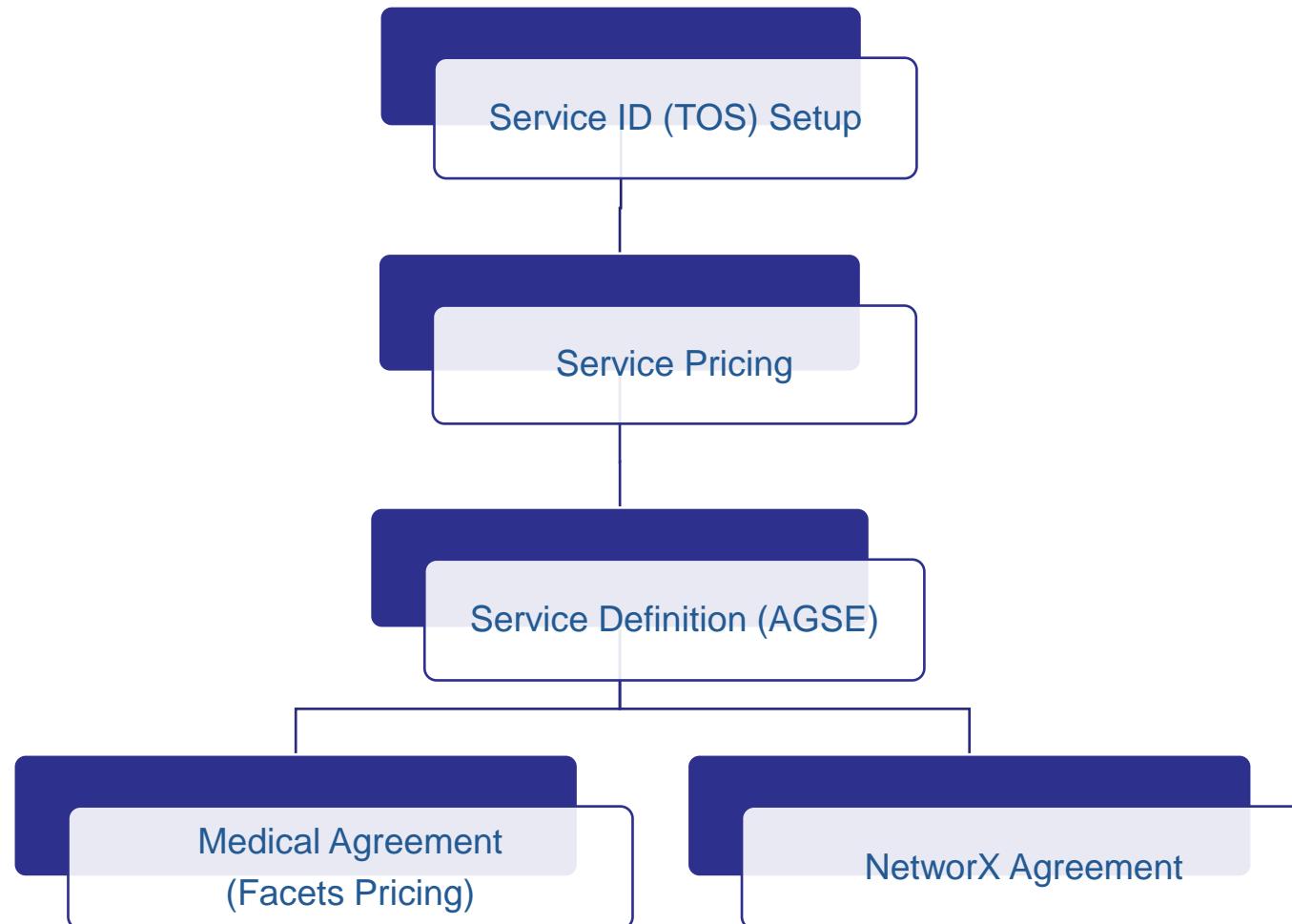
Facets - Service Pricing & Provider Agreement

Learning Services

Agenda

- Service Pricing
- Service Definition
- Sample NetworX Agreement Setup
- Sample Core Facets Agreement Setup
- Pricing Methods

Service Pricing- Agreement Structure



Service Pricing- Hierarchy

Service ID's are setup with the appropriate conversions rules

For each Service ID, Pricing ID is created to specify the associated rules

Pricing ID can be tagged to different type of Pricing Methods such as

- Allowed Amount
- Fee Schedule/ R&C
- DRG
- Per Diem etc..

Profile pricing can be setup for Provider, Network or Agreement and can be indicated in Pricing and Agreement applications

Service Pricing- Application

“Pay Profile Amount” indicates if Profile payment setup can be used.

Service Pricing defines Pricing Method and Charges Rule.

Depending on the Pricing Method chosen, appropriate prefixes has to be linked.

Charges rule indicates the calculation used to arrive at the final amount.

Service Definition - Application

A Prefix created to associate Pricing ID for each Service

Only one Price ID can be associated to a TOS under a given Prefix

Defines Capitation, Risk Withhold, Pre-auth and Referral requirements

Service Definition prefix is attached to Agreement (Facets or NetworX)

Service Definition prefix is attached to product as SEDF prefix and attached to agreement as AGSE prefix

Note:

- If claims cannot find provider agreement, SEDF at product level is used for Pricing.

Medical Agreement

An agreement represents an MCOs contract with a provider

Agreement can be setup as Core Facets Agreement or NetworX Pricer

Establishing rules for provider's

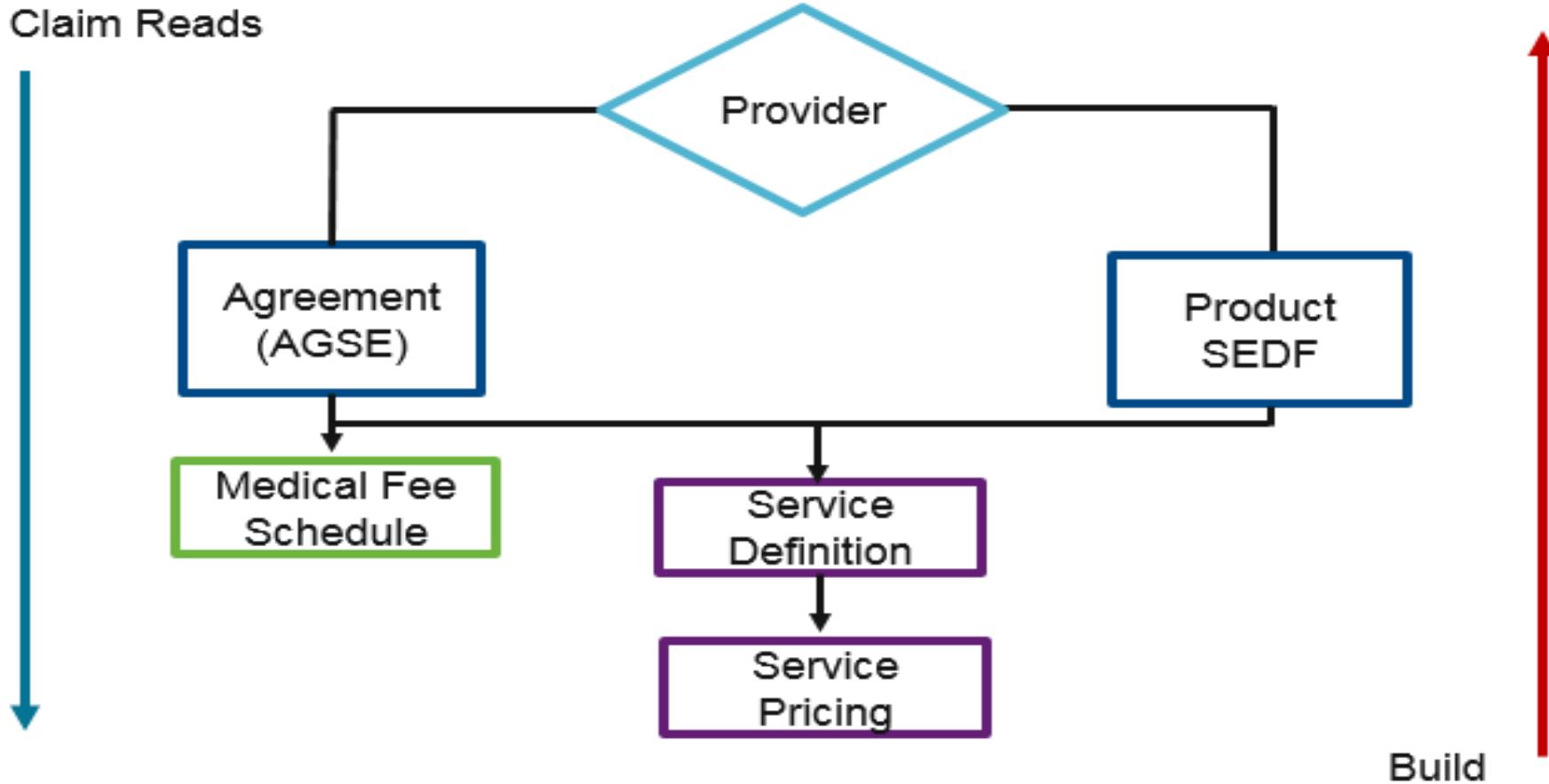
- Inpatient and outpatient claims
- Setting up provisions for discounts, risk-withhold, stoploss
- Special pricing considerations
- Determining if a profile pricing exists

Service Definition (AGSE) is a required prefix for an Agreement

Payment Drag can be established. Takes precedence over the setup in AIAI

Can be attached to In-Network section and Out of Network section to define Non-Participating Agreement

Pricing and Agreements Overview



NetworX – Medical Agreement Configurator



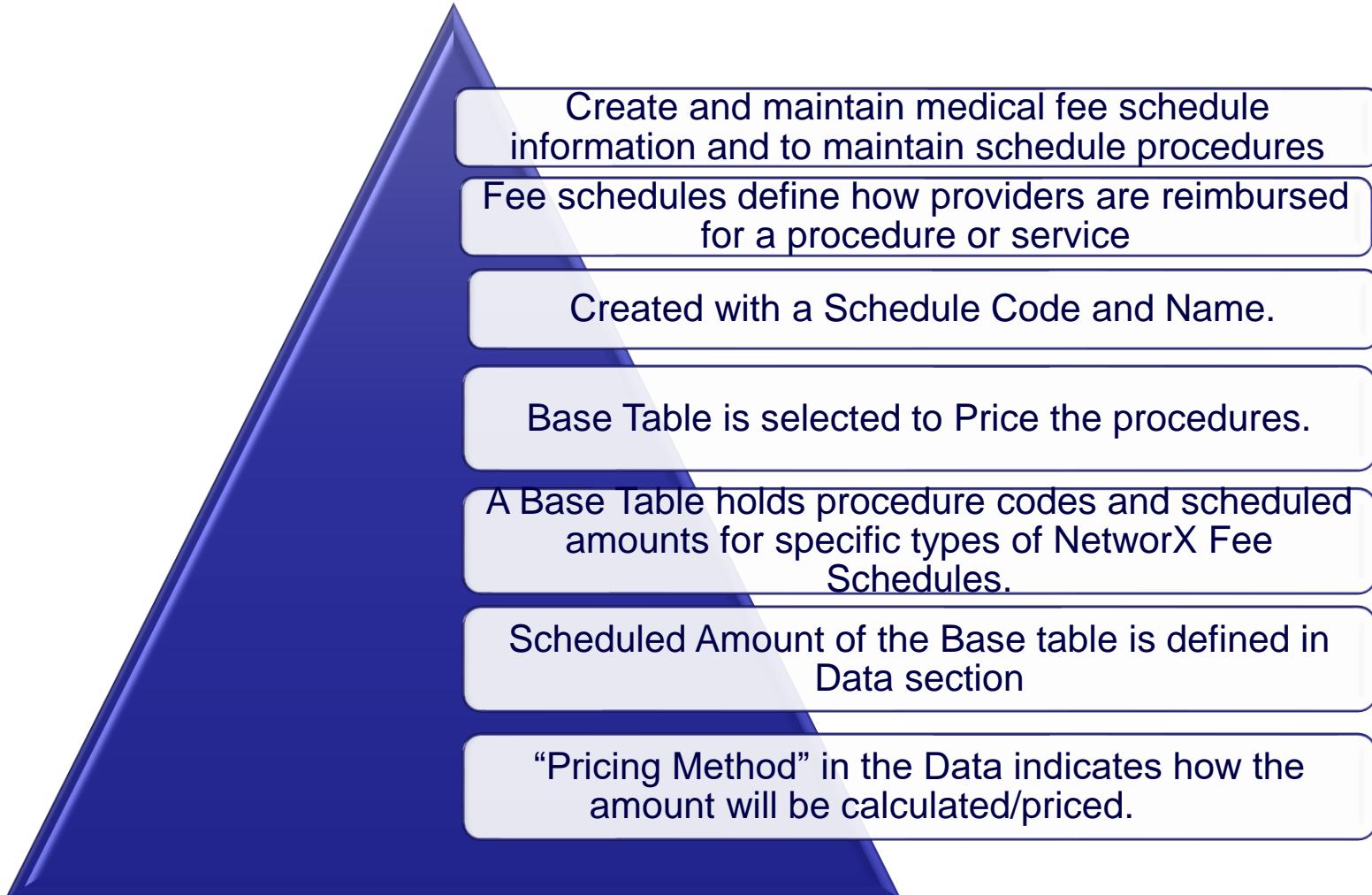
Separate application for configuring Agreements & Integrated with Facets.
Create and/or maintain medical agreements
View all the component information attached to a specific agreement.
The AGSE/Service Definition and Pricing Type Agreement subsections are required for a NetworX contract
Core Facets Agreements can also be viewed here.
In-Network section and Out of Network section to define Non-Participating Agreement

NetworX – Medical Agreement Configurator

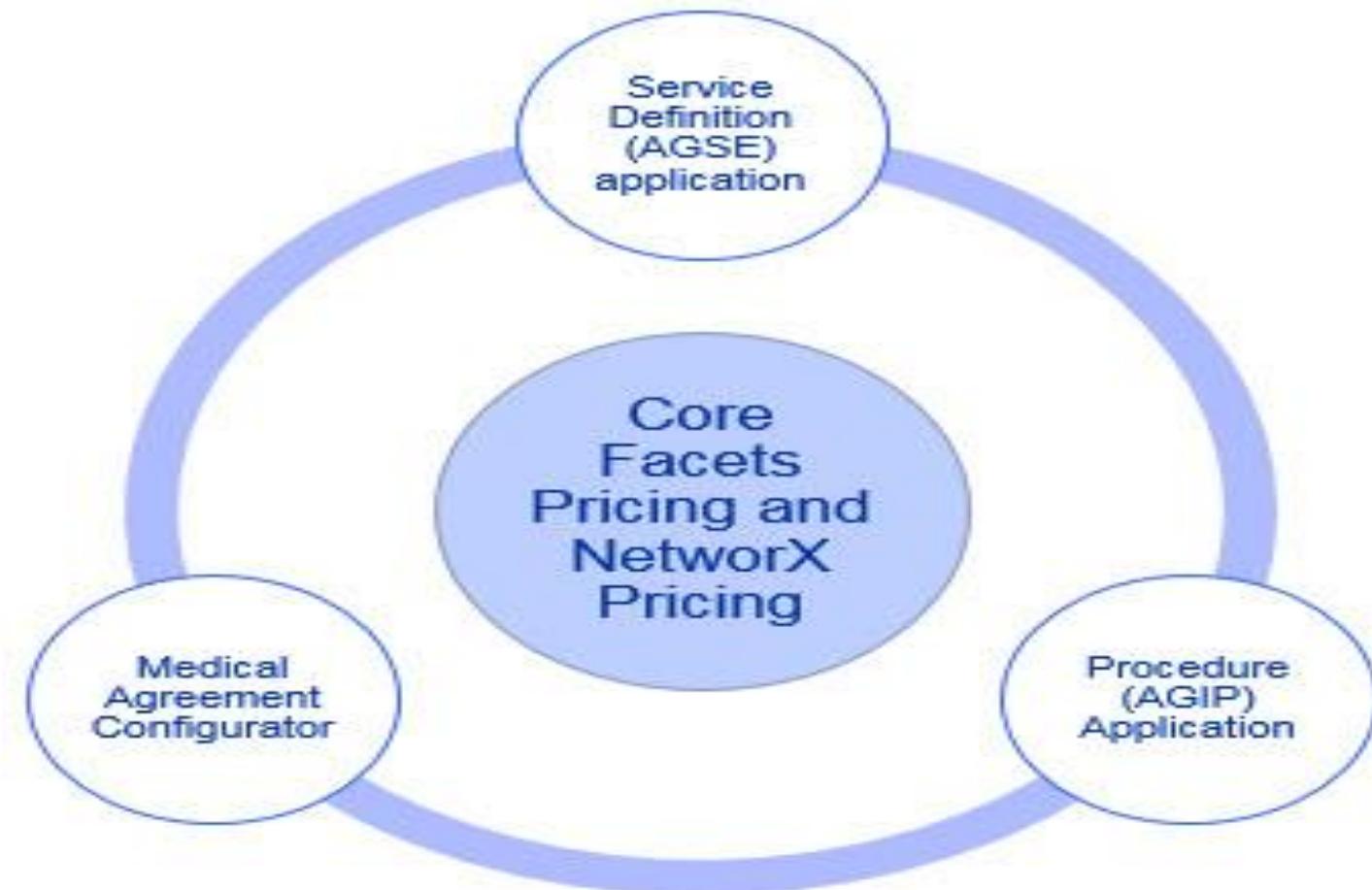
Steps to set up new Agreement:

- File -> New and provide Agreement ID and Description
- Edit -> Add -> Section ; Setup Effective and Term dates
- Add rows in Agreement Subsection (Right Click -> Add).
- Pricing Type and AGSE Prefix are mandatory.
- Add rows in Contract Section. (Right Click -> Add Contracts)
- Terms of an Agreement are defined in Contract Section
- Terms are used to price a service that matches the **Contract Section** and term qualifiers.

NetworX – Medical Fee Schedule



Facets and NetworX Pricing Applications



Agreement, Medical Application

Available in the Medical Provider Agreement application group allows you to establish or edit an agreement between a health plan and providers.



A number of providers (a provider group or an IPA) can share an agreement, or an entire network of providers can share the same agreement.



Before any information can be added on the tabs on the Indicative page, the agreement must have an Effective date.



Claim-Accept Months - The entry here overrides the entry on the Administrative Information record.



Agreement, Medical Application – Contd..

Profile Payment level is setup. Works in tandem with Profile payment setup in Service Pricing.



Indicates if NetworX pricing is used for Professional or Hospital claims.



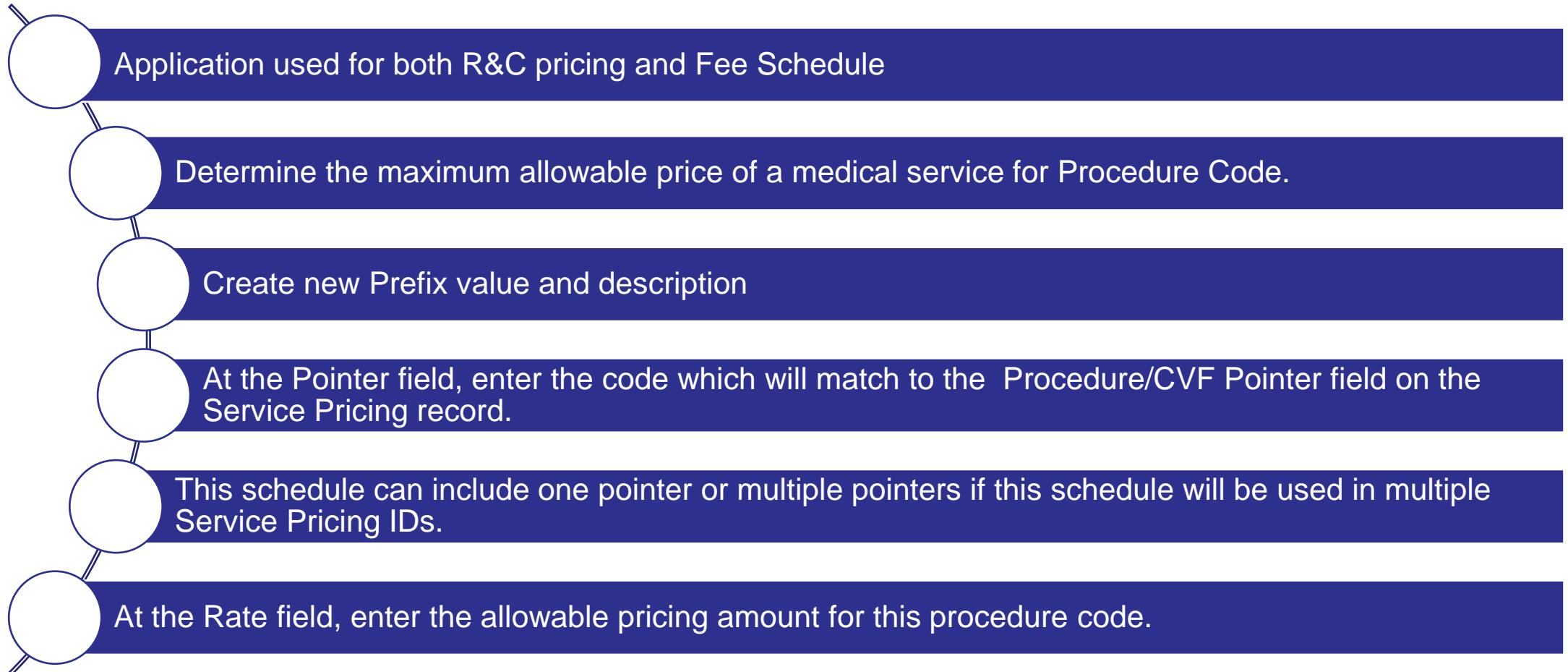
Prompt pay discount can be setup. Prefix should be attached in the Related Prefixes tab.



AGSE (Service Definition) is the only mandatory prefix to be attached



R&C/Schedule, Medical Application (IPRS)



Pricing Methods

Providers can be reimbursed through a variety of pricing methods.

Pricing Methods	Definition
Amount	Services that will always price at submitted charges.
Schedule	Pre-negotiated flat amount for a specific provider(s), for specific services. Identified by CPT and HCPCS procedure codes.
R&C	Schedules defining reasonable & customary charges for a region of providers
CVF	Pricing where a Relative Value Unit (RVU) for a specific procedure (identified by CPT procedure code) is multiplied by a Conversion Factor (CVF).
RBRVS	Established by Medicare; uses extended RVU x CVF logic.
Anesthesia Pricing	Takes into account time as well as procedure (normal, round up or MDR).

Pricing Methods – Contd..

Pricing Method	Definition
Rate	Services pay at rate entered by user. Used for hospital services that have to be calculated, e.g., chemotherapy drugs
DRG	State Mandated, Medicare Inpatient Prospective Payment System; can use HSS Grouper Software.
Per Case	Incorporates all services for one provider in one episode.
Per Diem	Payment per day for services.
Ambulatory Surgical Centers (ASC)	Medicare Outpatient Prospective Payment System.
Ambulatory Payment Classification (APC)	Medicare Outpatient Prospective Payment System (Year 2000).

Note

Certain Pricing methods used Zip code/Region as one of the parameters.
Provider's Primary address is used for Zip code in Pricing related applications



Questions?



Thank you



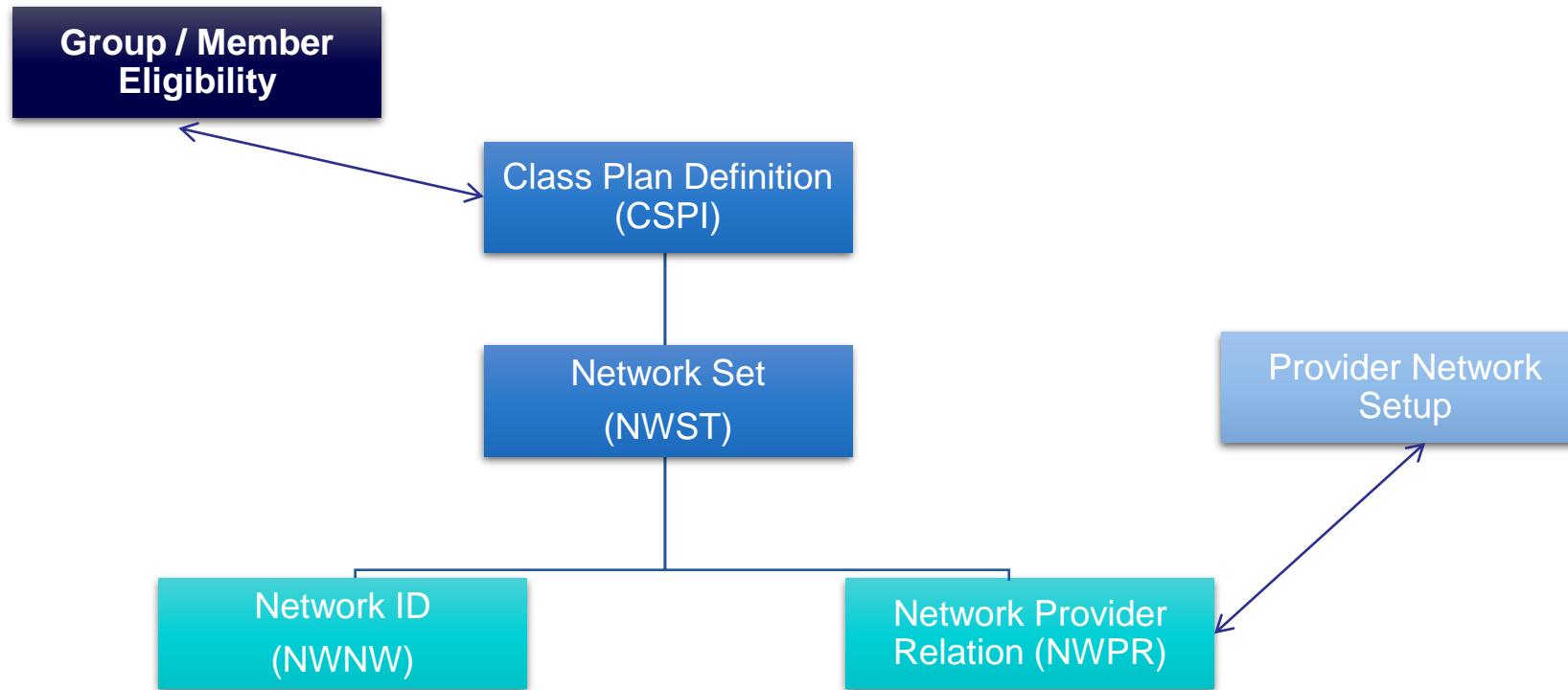
Networks

Learning Services

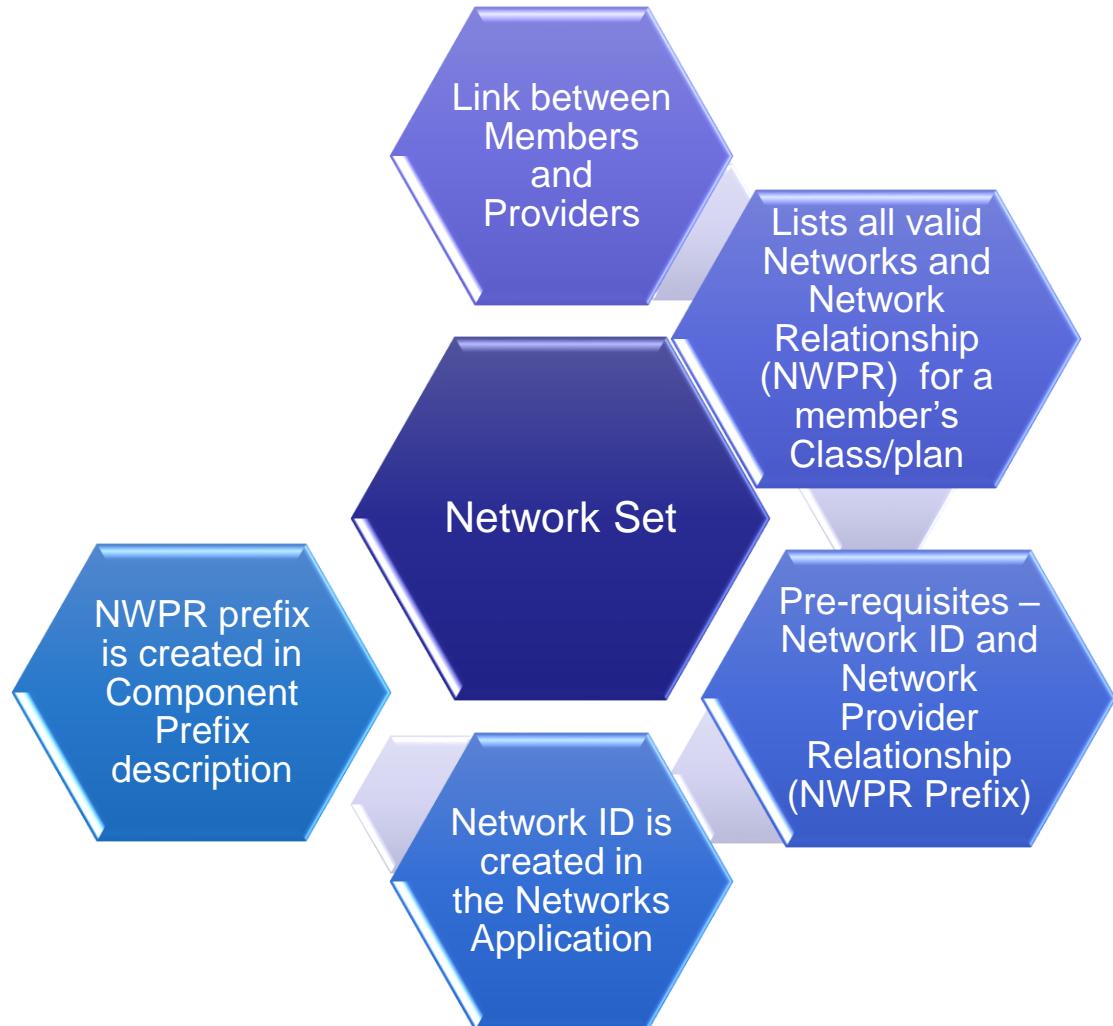
Agenda

- Network/Plan Structure
- Network Set Application
- Provider Network Relation
- Provider Out of Network Relation
- Claims Flow

Network/Plan Structure



Network Set



Related Applications

- Establish Network
- Indicative – Contains ID, Name and Address
- Can be tied to a Network Group for reporting purpose.

Network Application

- Application where prefixes are created/listed.
- Following prefixes are directly created in this application.
 - Network-Provider Relationship (NWPR)
 - Non-Participating Provider Relationship (NPPR)
 - PCP Capitation Network Provider Entity Relationship (NWPE)
 - Specialist or Global Capitation Network Provider Entity Relationship (NWCR)
 - Covering Provider code (PRCV)
 - Provider Accumulators (PRAC)

Component Prefix Description:

Network Set Application



Application is in Medical Plan Application group

Link Network ID with appropriate NWPR Prefix and indicate Status.

Tier will need to match with the tier of Product Variable component.

In-Area Bypass is set to Yes (Y) to bypass this Network Set row during claims processing when the provider's zip code falls within a specified range defined in the **Zip Codes** section tab

Network Set Application – Contd..

Status is that of the provider with this type of relationship will have within this network .

- Providers with a NWST Status of “I” are considered “In-Network”
- If the network provider is also the member’s PCP, he/she is considered to be a PCP
- Providers with a NWST Status of “P” are considered “Participating”
- Providers not linked to the NWST prefix for a member’s product are considered “Non-Participating”

Status will be used to identify Provider status in Product Variable component.

Network Provider Relationship

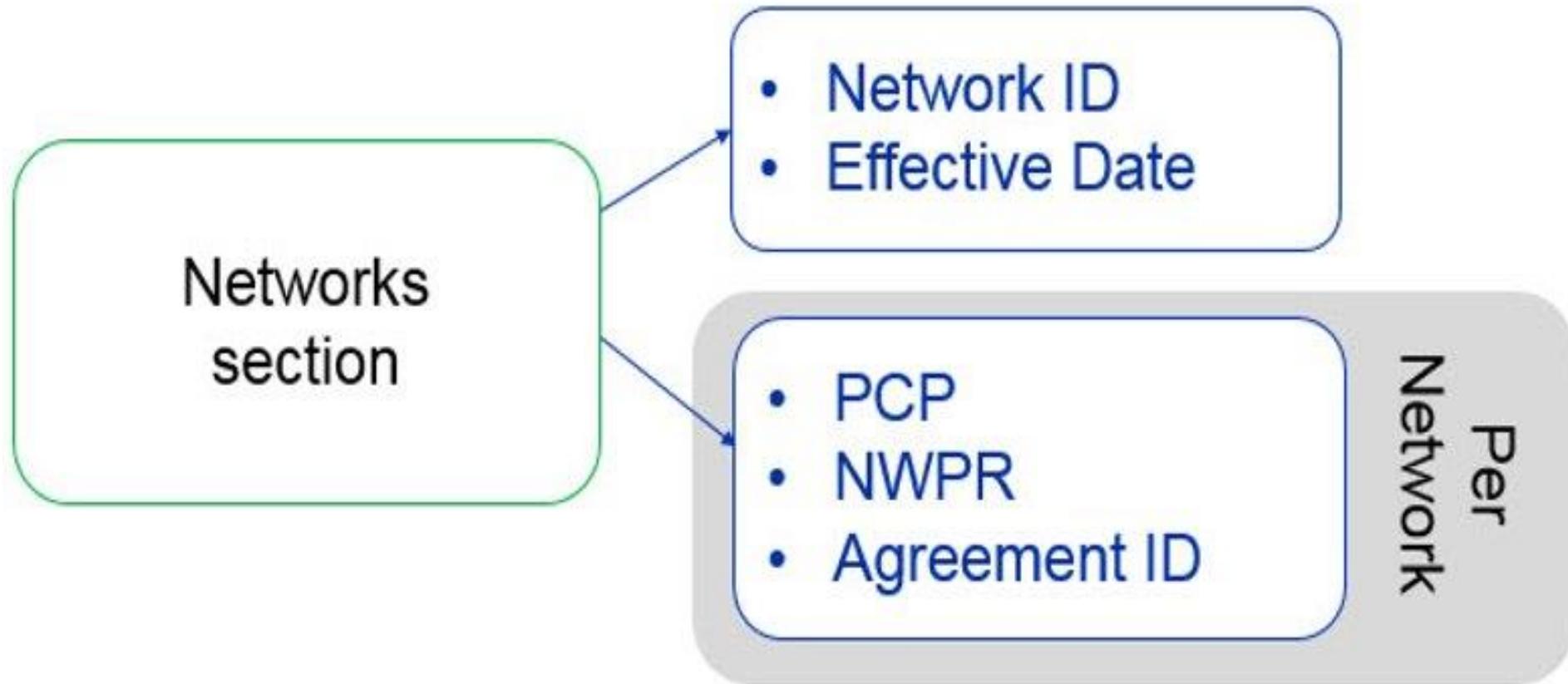
Network Relationship of Provider is established in Networks Section.

A network relationship for a provider must include a Network ID, and NWPR prefix, and an agreement ID

If the PCP is set as Y, then the NWPR is considered as PCP Relation.

Otherwise, it is considered as Specialist Relation

Network Provider Structure



PCP Relationship

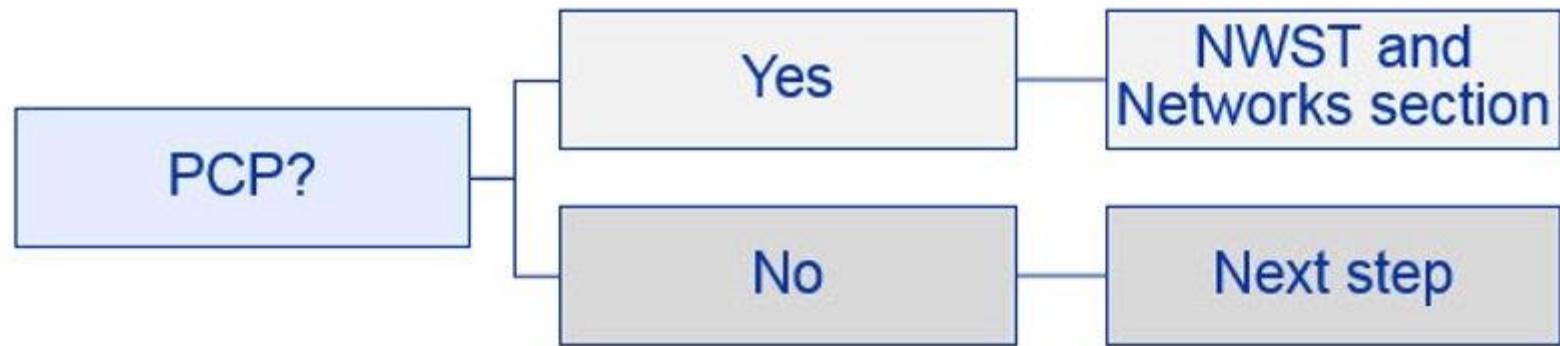
In order for a PCP to be recognized as such, the following conditions must be true:

The provider has a PCP row on the Network Relationship table (NWPR)

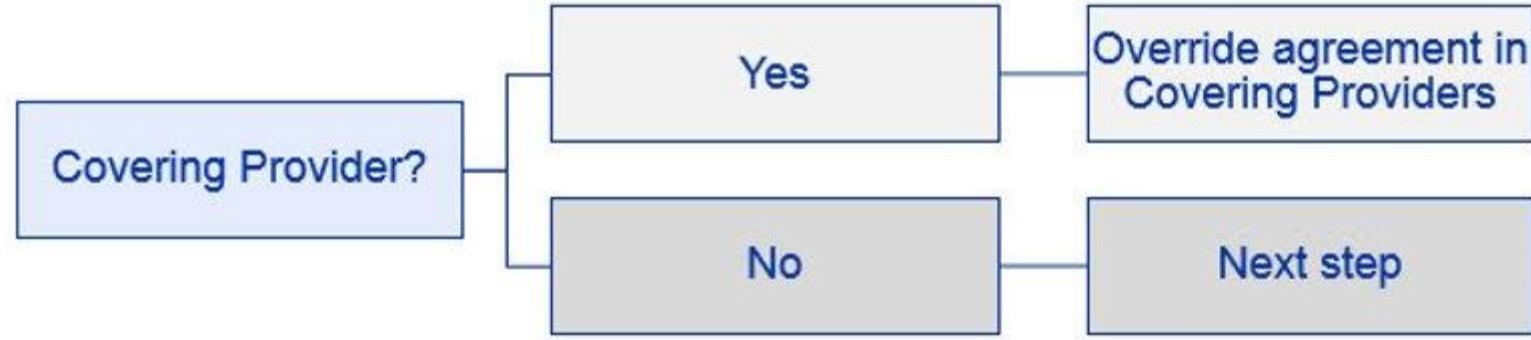
The NWPR matches to a row within a Network Set for a member's product where the Network Status on the row is 1 (In-Network)

The provider is selected by a member via the Member-Provider Relationship table (MEPR)

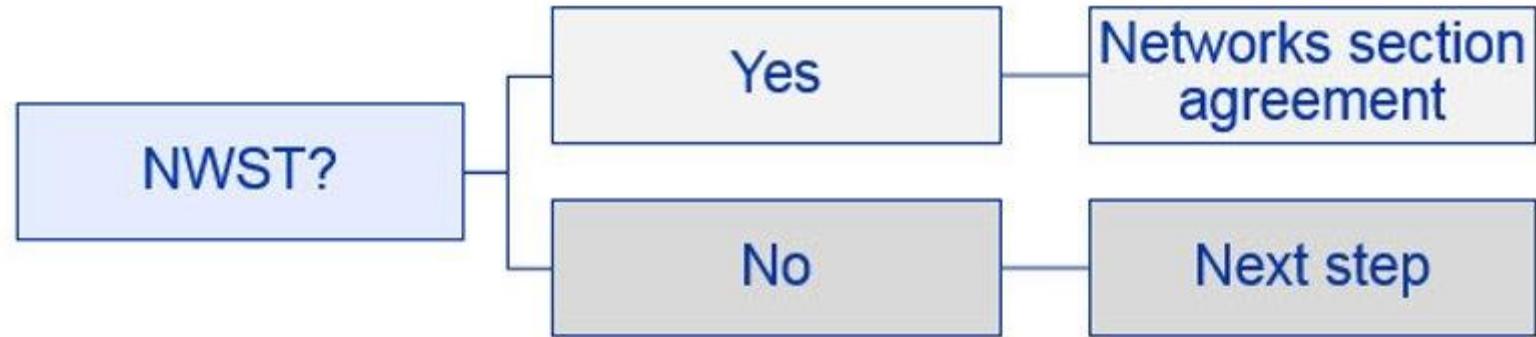
Network-Provider Process Flow: PCP



Network-Provider Process Flow: Covering Provider



Network-Provider Process Flow: NWST



Network-Provider Process Flow: Servicing Provider



Out of Network Providers

Also called as
Non
Participating
Relationship

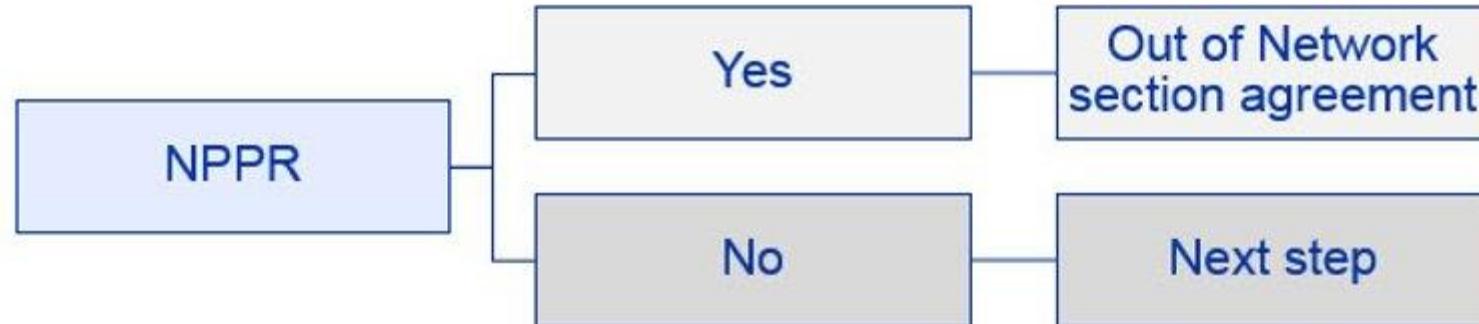
Provider sets
up no network
relationship,
yet negotiates
a payment
methodology

NPPR Prefix is
created in
Components
Description
application

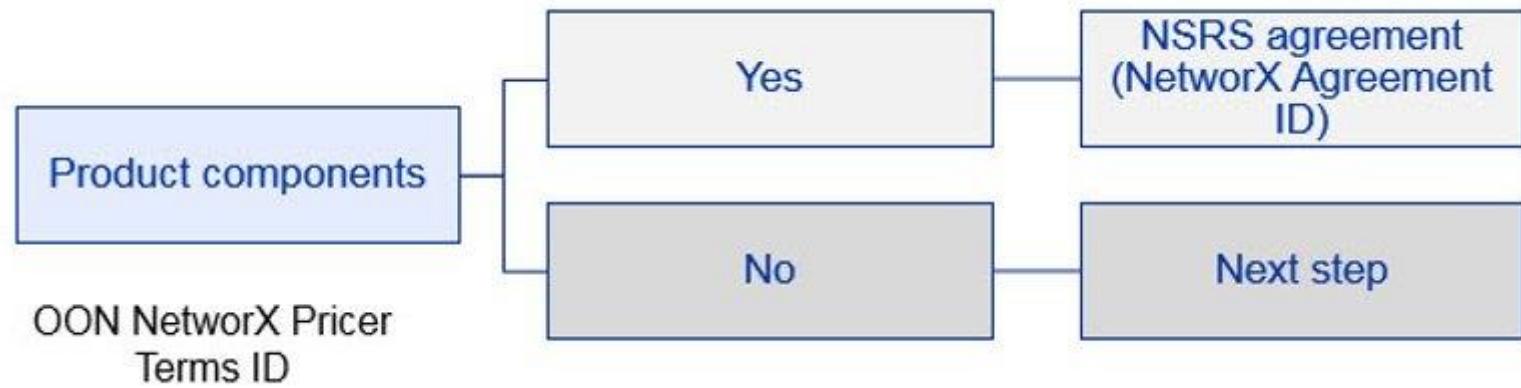
NPPR
component
attached to the
product

NPPR prefix
added to the
Out of Network
Section of
Provider with
an agreement
ID

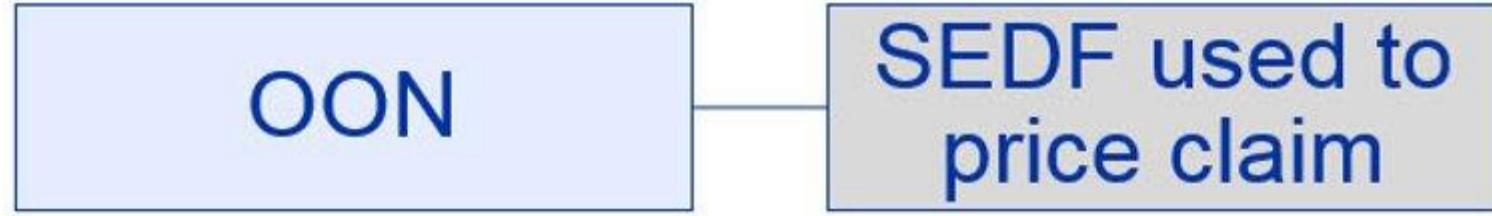
Network-Provider Process Flow: NPPR



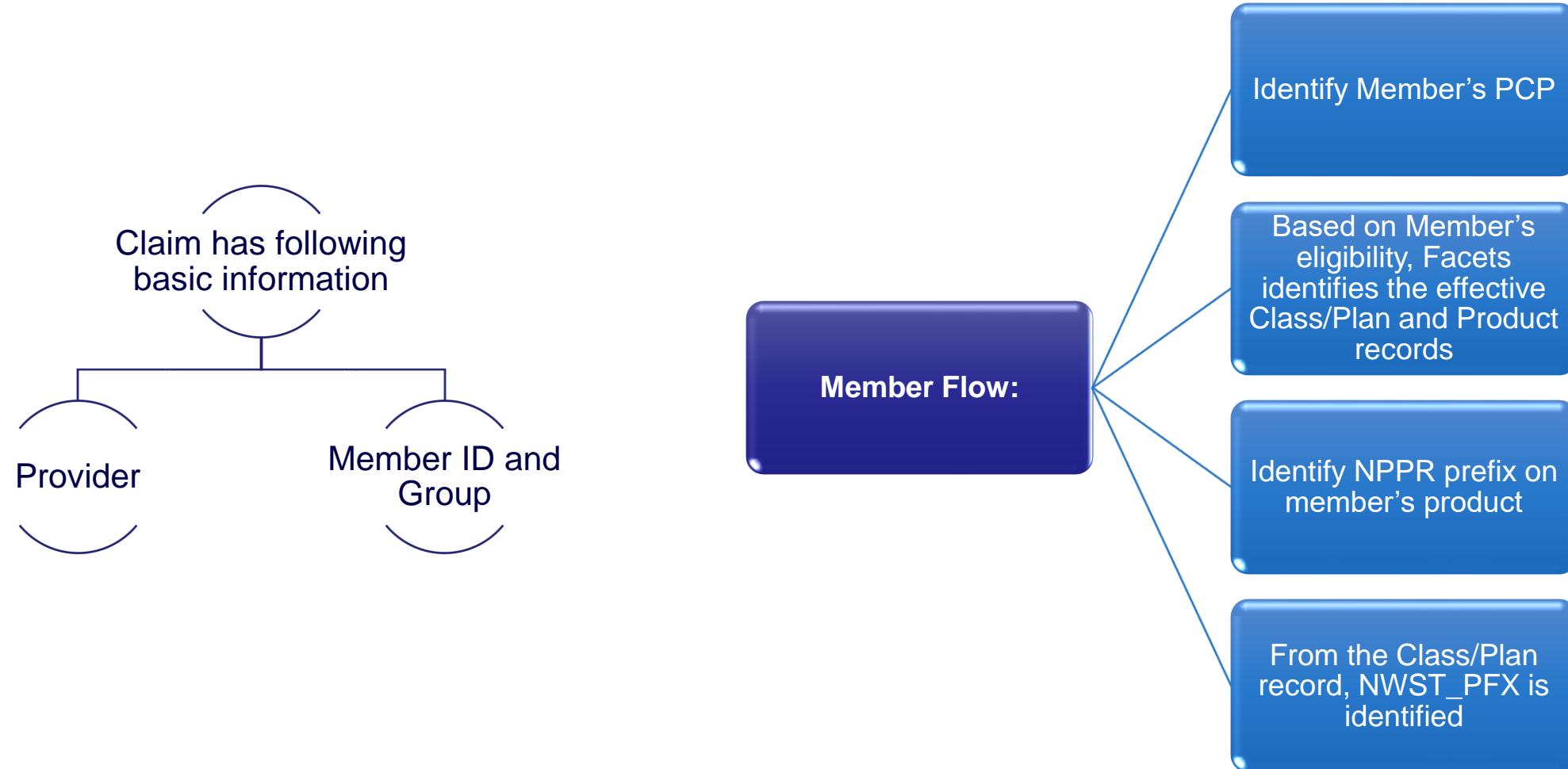
Network-Provider Process Flow: Product Components



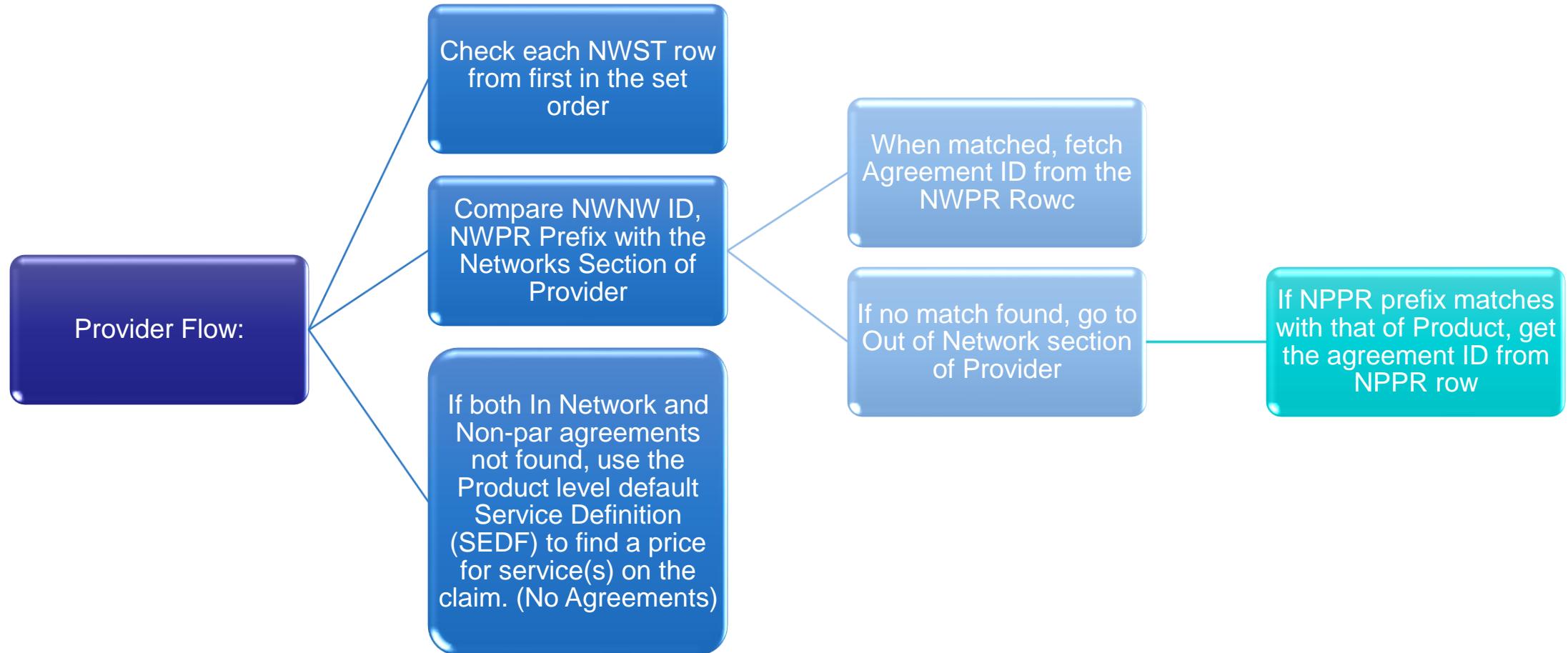
Network-Provider Process Flow: OON



Claims Flow



Claims Flow – Contd..





Questions?



Thank you



Facets – Service Payment and Service Conversion

Learning Services

Agenda

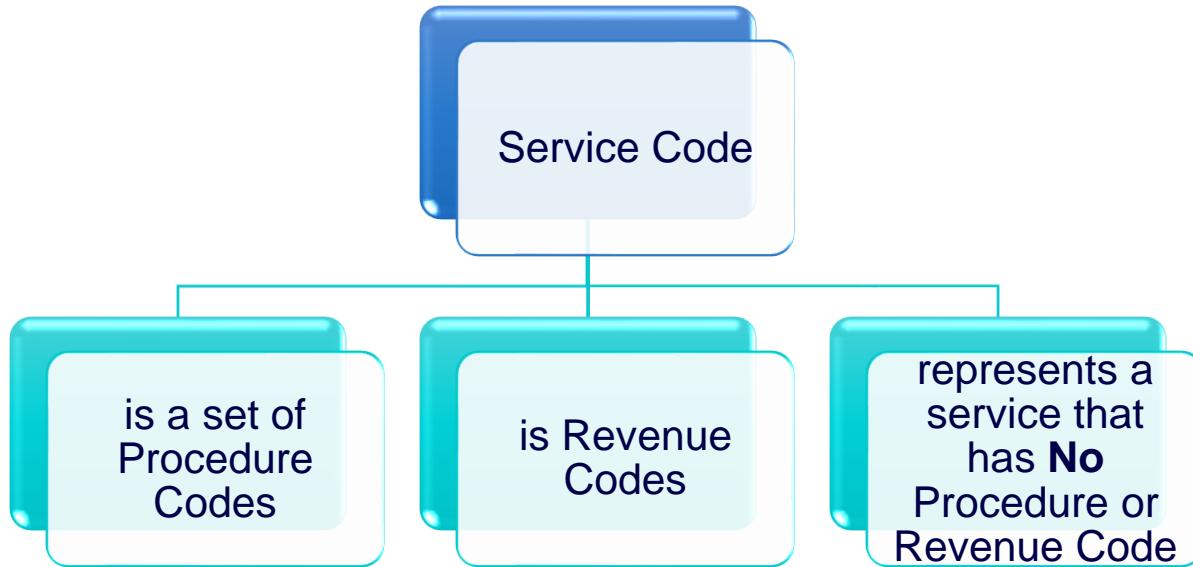
Service Payment Setup

- Service ID Descriptions (SEDS)
- Service Rule Definition (SESE)
- Service Related Parameters(SERL)
- Service Payment (SEPY)

Service Conversion Setup

- Service / Procedure Conversion(TPCT)
- Service / Revenue Code Conversion (RCCT)
- Service Code Conversion (SECT)

Services



Setting Up a Service for Pricing and Payment

Step 1. Create a Service (SEDS)

Step 2. Define the Service (TPCT, RCCT,SECT)

Step 3. Modify the Service (SPCT, SRCT)

Step 4. Create Service Rules (SESE)

Step 5. Create the Service Payment record (SEPY)

Step 6. Create the Service Pricing record (SEPC, Schedule, R&C, R&B, Per diem/ per case)

Step 7. Tie Services together (SEDF , AGSE)



Service Payment

Service Payment Set up



Step 1: Create a Service
(SEDS)



Step 2: Create Service Rules
(SESE)



Step 3: Create the Service Payment Record
(SEPY)

Service Rule Definition

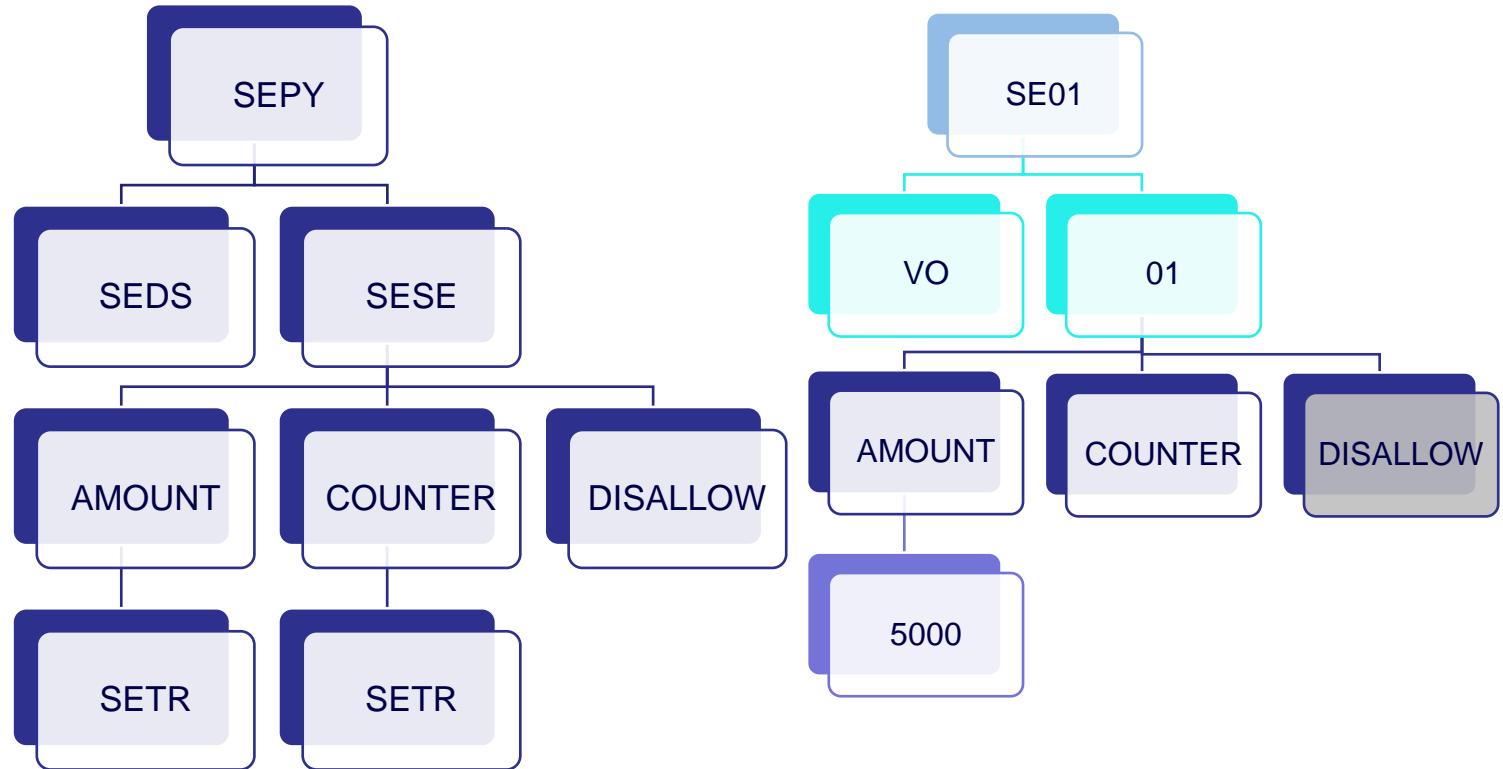
SESE:

- Defines type of services and the rule of payment applicable to each service
- You can:
- Add information
- Edit Information

Service Payment Setup – Contd..

Service Payment Application (SEPY)

- It allows users to link service rules to types of service
- Experience and Accounting Categories are user-defined fields that also appear on the Billing Component application.
- Agreement between Enrolled member with an Insurance company
- Talks about Copay / Coinsurance / Deductibles(DEDE)



Service Payment Setup – Contd..

Service Tier Tab (SETR) (Applicable for Amount and Counter base)

- Can establish up to nine tiers
- Counter based services - number of units submitted
- Amount based services - on the allowable dollar amounts
- Service rules set up to Disallow will use an allowable amount of 0 during claims processing and display the explanation code entered. When this type of rule is set up, no service tiers can be associated with it..
- Deductible Accumulator refer Accumulator Description (App. Support) – Deductible Rules / Limit Rules (Medical Plan)

Service Payment Setup – Contd..

Counter Based Example:

When 25 visits is billed, it would take only 100\$ as copay.

Remaining will fall under tier3, without copay

Tier	Counter	Copay	Value
1	5	10	= $5 \times 10 = 50$
2	10	5	= $10 \times 5 = 50$
3	999	0	

In Tier 1 : First 05 visits Visit 01 to Visit 05 : For Each visit \$10.00 as Copay

$$\begin{aligned} &= 5 \text{ Visits} * \$10.00 \\ &= \$50.00 \end{aligned}$$

In Tier 2 : Next 10 visits Visit 06 to Visit 15 : For Each visit \$ 5.00 as Copay

$$\begin{aligned} &= 10 \text{ Visits} * \$5.00 \\ &= \$50.00 \end{aligned}$$

In Tier 3: Next 10 visits Visit 16 to Visit 25 : For Each visit \$ 0.00 as Copay

$$\text{Total Copay} = \$100.00$$

Service Payment Setup – Contd..

Amount Based Example:

When \$10,000.00 is billed, \$15 copay would be taken (10+5) and 200% of co-insurance

A	B	C	D	E	F	
Tier	Amount Splitup	Amount	Co-insurance	Co-Payment	B-D	E*C
1	1000	\$1,000.00	80%	\$10.00	\$ 990.00	\$ 792.00
2	5000	\$1001 to \$ 5000= \$ 4000	100%	\$5.00	\$ 3,995.00	\$ 3,995.00
3	9999999	\$ 5001 to \$10000=\$ 5000	100%	\$ -	\$ 5,000.00	\$ 5,000.00
				Total	\$ 9,787.00	

In Tier 1: For First \$1000.00 : Copay \$10.00 ; Colns: $(\$1000.00 - \$10)*80\% = \$792.00$

In Tier 2: Tier 2 – Tier 1 Limit; \$4000.00 : Copay \$ 5.00 ; Colns: $(\$4000.00 - \$5)*100\% = \$3995.00$

In Tier 3: remaining Amount - Tier 2; \$5000.00 : Copay \$ 0.00 ; Colns: $(\$5000.00 - \$0)*100\% = \$5000.00$

Service Payment Setup – Contd..

Service Penalty Dialog Box (SESP)

- Users can establish service penalties that are applied during claims processing. Some examples of when penalties can be applied are: UM guidelines were not followed, out of network situations etc.,

Service Related Parameters Application (SERL)

- It stores information on relationships between types of services, including parameters which must be satisfied in order for the services to relate together during claims processing
- Relate co-pay

Service Payment Setup – Contd..

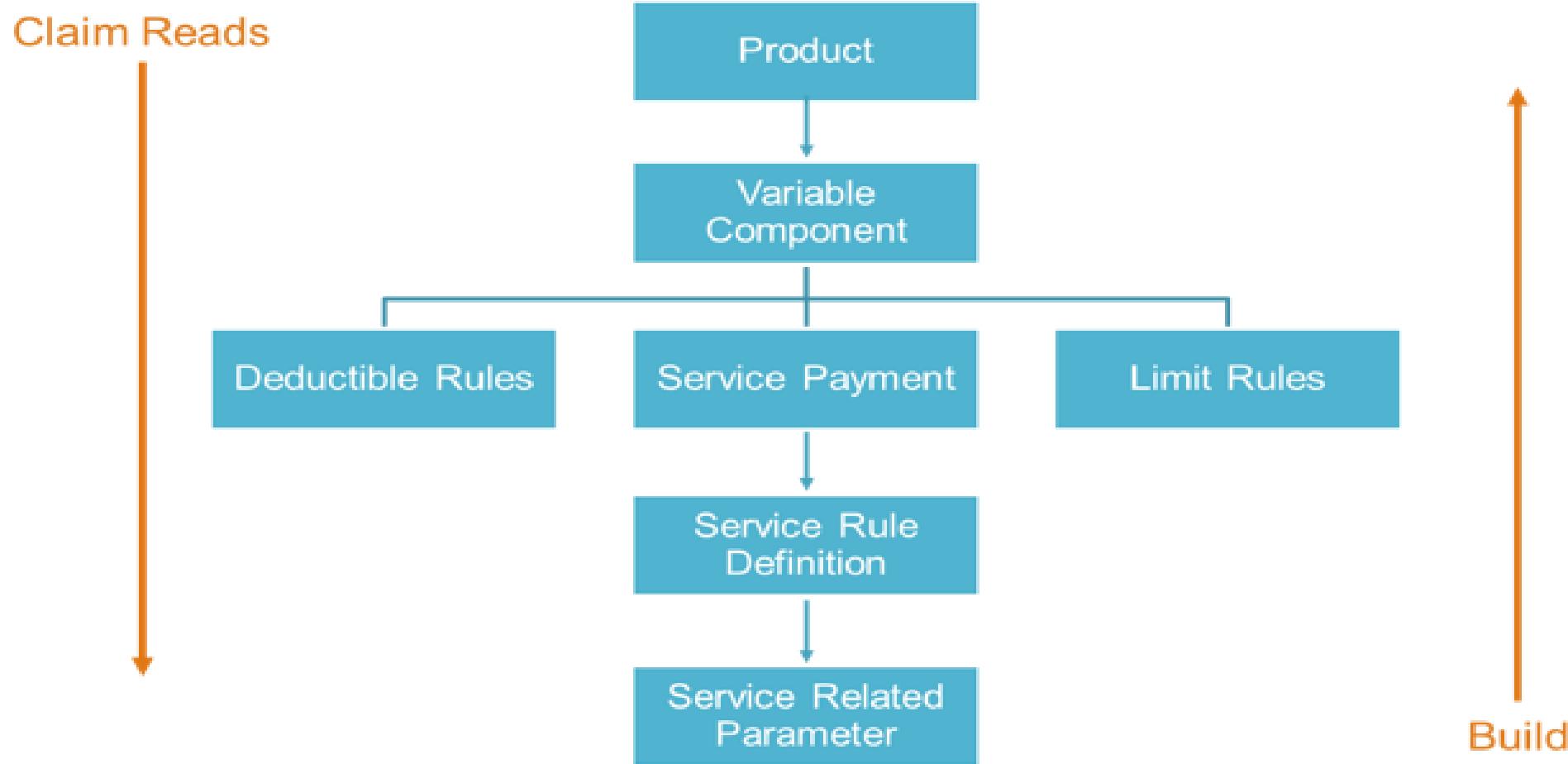
Medical Utilization Edits by Procedure (UTIP)

- Optional product component
- Establish dependencies based on a procedure code's relationship to other service IDs

Medical Utilization Edits by Service (UTSE)

- Optional product component
- Establish dependencies based on a service ID's relationship to other service IDs

Service Payment Flow





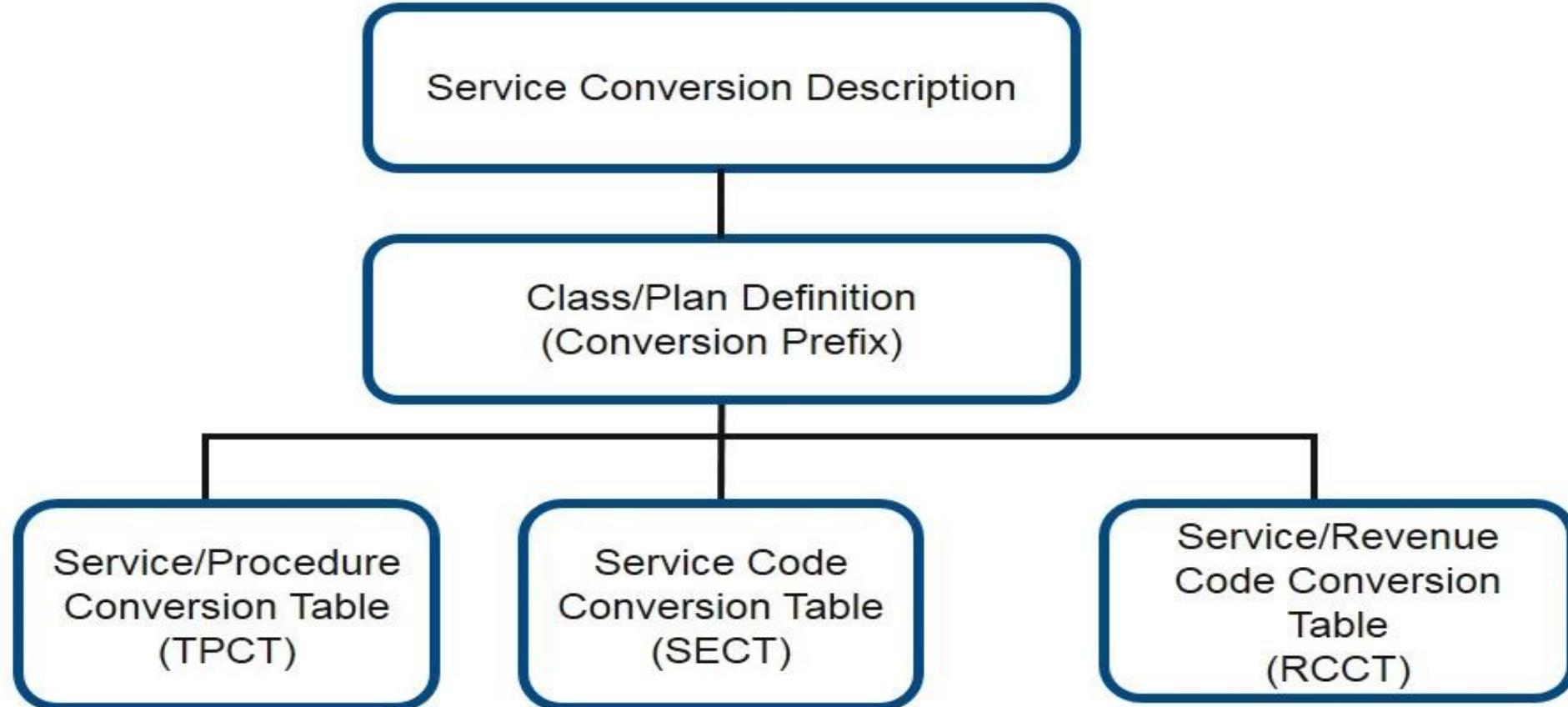
Service Conversion

Service Conversion - Hierarchy

Facets claims and UM processing applications will read the conversion tables based on the following hierarchy:

Medical Claims and UM	Hospital Claims
Supplemental Procedure Conversion Rules (SPCR)	Supplemental Revenue Conversion Rules (SRCR)
Supplemental Procedure Conversion (SPCT)	Supplemental Revenue Code Conversion (SRCT)
Service/Procedure Conversion (TPCT)	Service/Revenue Code Conversion (RCCT)

Service Conversion



Service Conversion – Contd..

Step 1:

Create a Service (SEDS)

Step 2:

Define the Service (TPCT, RCCT, SECT)

Step 3:

Modify the Service (SPCT, SRCT) → Optional

Step 4:

Create the Service Pricing Record (SEPC, Schedule, R&C,
R&B, Per diem/ per case)

Step 5:

Setting up Service Definition (List of agreed services –
mapped to SEPC) (SEDF*)

Service Conversion

Service/ Procedure Conversion (TPCT)

The Service/Procedure Conversion application (TPCT) defines how Facets converts procedure codes entered during claims or UM processing to a service code

This Application assist in the process of automating the submission of provider's services that are submitted using procedure codes

a user-defined Category linked to the Provider, Diagnosis and Place of Service applications

a user-defined Setting linked to the Place of Service, Medical application for the Service/Procedure

Conversion and linked to the Bill Code Definition application for the Service/Revenue Code Conversion applications

a procedure code modifier established in the Service/Procedure Conversion application

Service Conversion – Contd..

Service /Revenue Code Conversion (RCCT)

The Service/Revenue Code Conversion application (RCCT) lets you establish a range of hospital revenue codes for a product component prefix

The Service/Revenue Code Conversion application does not contain age range, gender, or modifier logic.

The Setting criteria is derived from the Facility Type entry and Billing Classification Code that are found on the UB-92 claim form

The Prefix Id for the Service Code Conversion (SECT), Service/Procedure Conversion (TPCT) and Service/Revenue Code Conversion (RCCT) must all be identical since they are identified on the **Class/Plan Definition** application as a single value

Service Conversion – Contd..

Service Code Conversion (SECT)

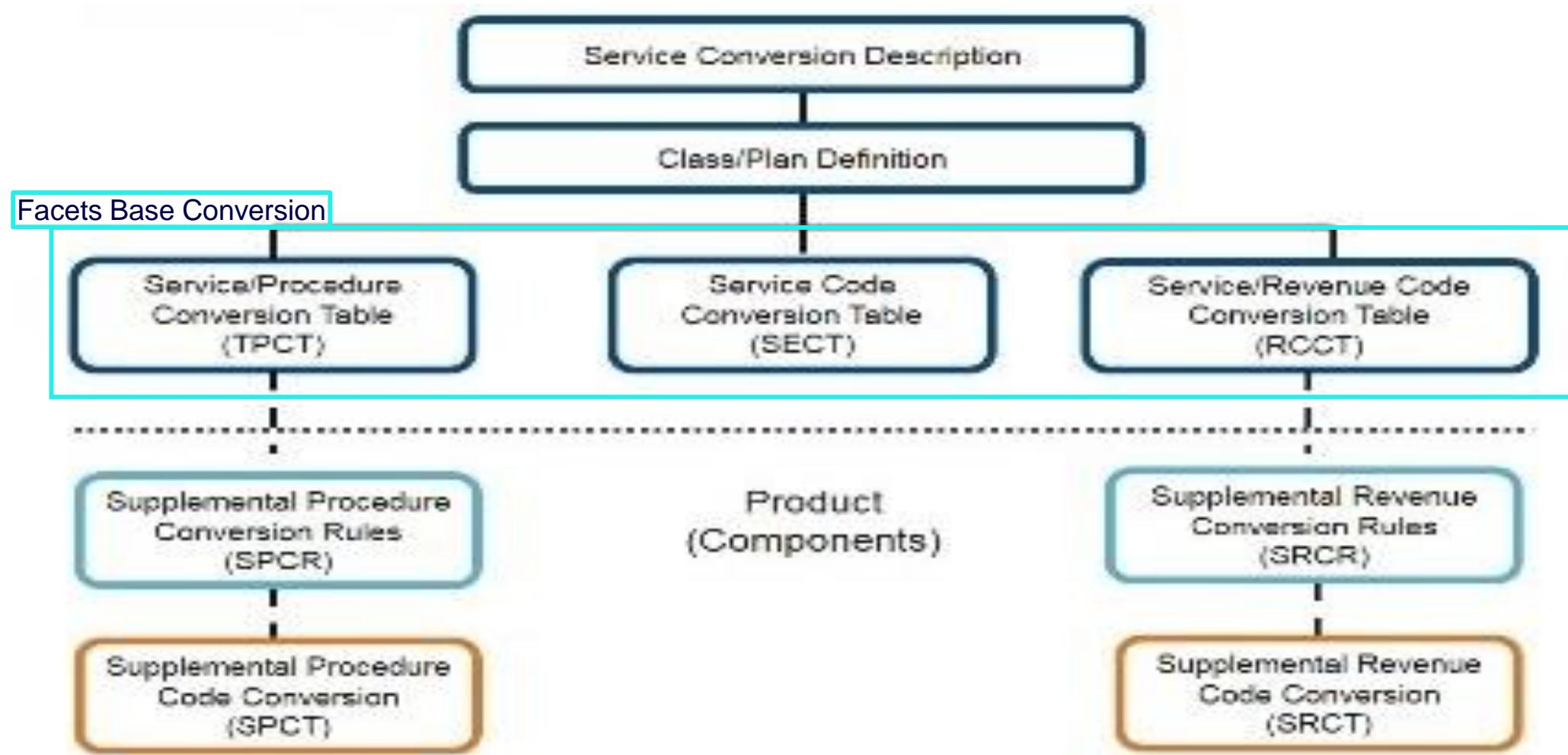
To determine the correct product class and reporting categories for a service code during claims processing,

Facets must match this service to a product category

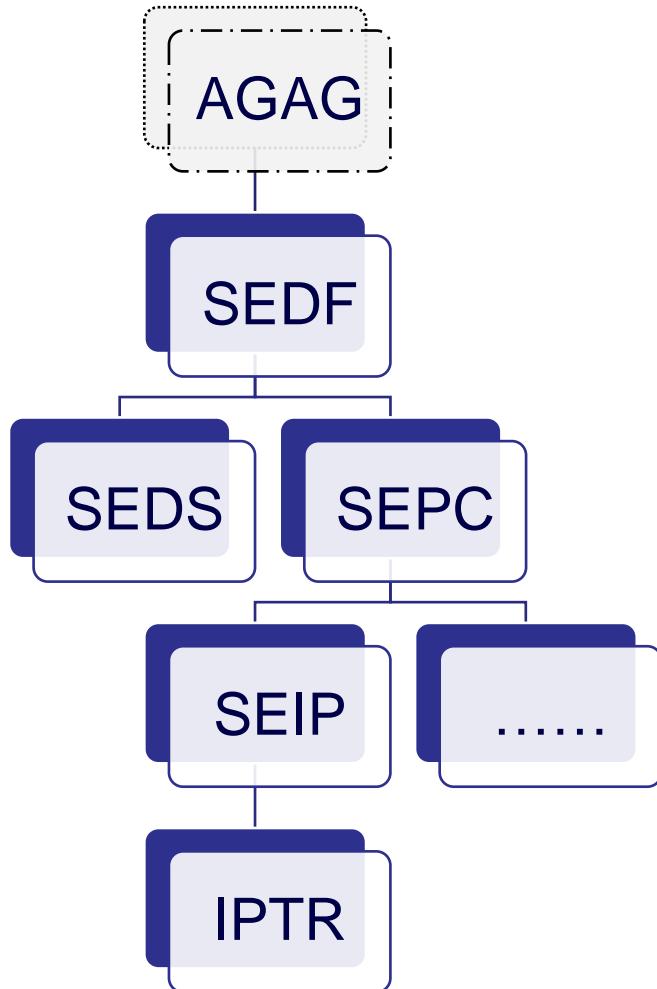
Facets searches the Service Code Conversion application when it cannot find the service through either the Service/ Procedure Code Conversion or * Service/Revenue Code Conversion applications

Example: Durable Medical Equipment,
UM Review etc.,

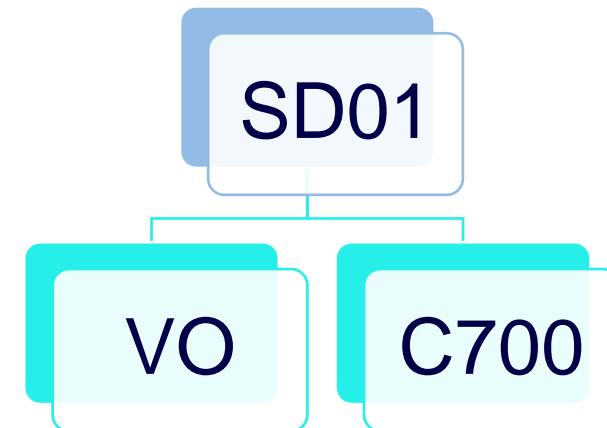
Service Conversion – Contd..



Service Definition Setup



- Pricing method for Provider - Agreed between **Provider and Insurance company**
- Talks about Pricing for a provider from Insurance company





Questions?



Thank you

Appendix

Tables

Application	Table Name
Service ID Descriptions	CMC_SEDS_SE_DESC
Service/Procedure Conversion	CMC_TPCT_CPT_CONV
Service/Revenue Code Conversion	CMC_RCCT_CONV
Service Code Conversion	CMC_SECT_CONV
Service Rule Definition	CMC_SESE_SERVICE
Service Payment	CMC_SEPY_SE_PYMT
Service Pricing	CMC_SEPC_PRICE
R&C / Schedule, Medical	CMC_IPRS_PRICE
Procedure Tiers	CMC_IPTR_PROC_TIER
Service Definition	CMC_SEDF_SE_DEFN
Service Conversion Description	CMC TPPX_DESC

Service Conversion

Supplemental Procedure Conversion (SPCT)

- This enables you to define additional rules at the product level as a supplement to the Service / Procedure Conversion application within a product
- This used to translate a procedure code to a service code using criteria such as age, gender, provider type and other parameters.
- It allows Facets to find a service ID within the Service/Procedure Conversion application based on a few parameters

Service Conversion – Contd..

Supplemental Revenue Code Conversion (SRCT)

- The Supplemental Revenue Code Conversion application (SRCT) enables you to define additional rules at the Product Level
- Very similar to SPCT

Supplemental Conversion Qualifier Group (SCQG)

- The Supplemental Conversion Qualifier Group application (SCQG) enables customers to configure Qualifier Groups for use in the Supplemental Procedure Conversion Rules and Supplemental Revenue Code Conversion Rules applications
- Qualifier groups define service codes (sections) and rules (conditions) that will be used in the conversion.

Service Conversion – Contd..

Supplemental Procedure Conversion Rules Application (SPCR)

- The Supplemental Procedure Conversion Rules application (SPCR) enables customers to establish a single set of rules that supports supplemental conversion for both Claims and UM processing
- Avoiding the need for rules for Claims and a separate set of rules for UM.
- Customers establish a prefix, which represents one rule group
- Each rule group will contain a section for each service code for which supplemental conversion must occur
- Each section can contain one or more rules.
- Each rule represents a condition or group of conditions, and the corresponding service code and report category that will be assigned if those conditions are met

Service Conversion – Contd..

Step Adding Supplemental Procedure Conversion Rules Procedures

- To add a new service code, select Add, Section from the Edit menu. In the *Add Section Dialog* box, all the service codes and descriptions that exist on the system display in the Service Code drop-down list.
- Select a service code, then select the appropriate Qualifier Group representing the service code from the Available Pick List and move it to the Included list using the right arrow button. The entry in the Included list can be moved to the Available list by selecting it and selecting the left pointing arrow.
- Select OK to close this dialog box and display the included qualifier group on the *Indicative Page*. Sections will be numbered in the order in which they were added. The qualifier group representing the service code must be established to save the record

Service Conversion – Contd..

Supplemental Revenue Conversion Rules Application (SRCR)

- The Supplemental Revenue Conversion Rules application allows users to establish a set of supplemental conversion rules. Supplemental Revenue Conversion rules are applicable to hospital claims processing only;
- UM does not use Supplemental Revenue Conversion
- Very similar to SPCR



Facets Subscriber & Member

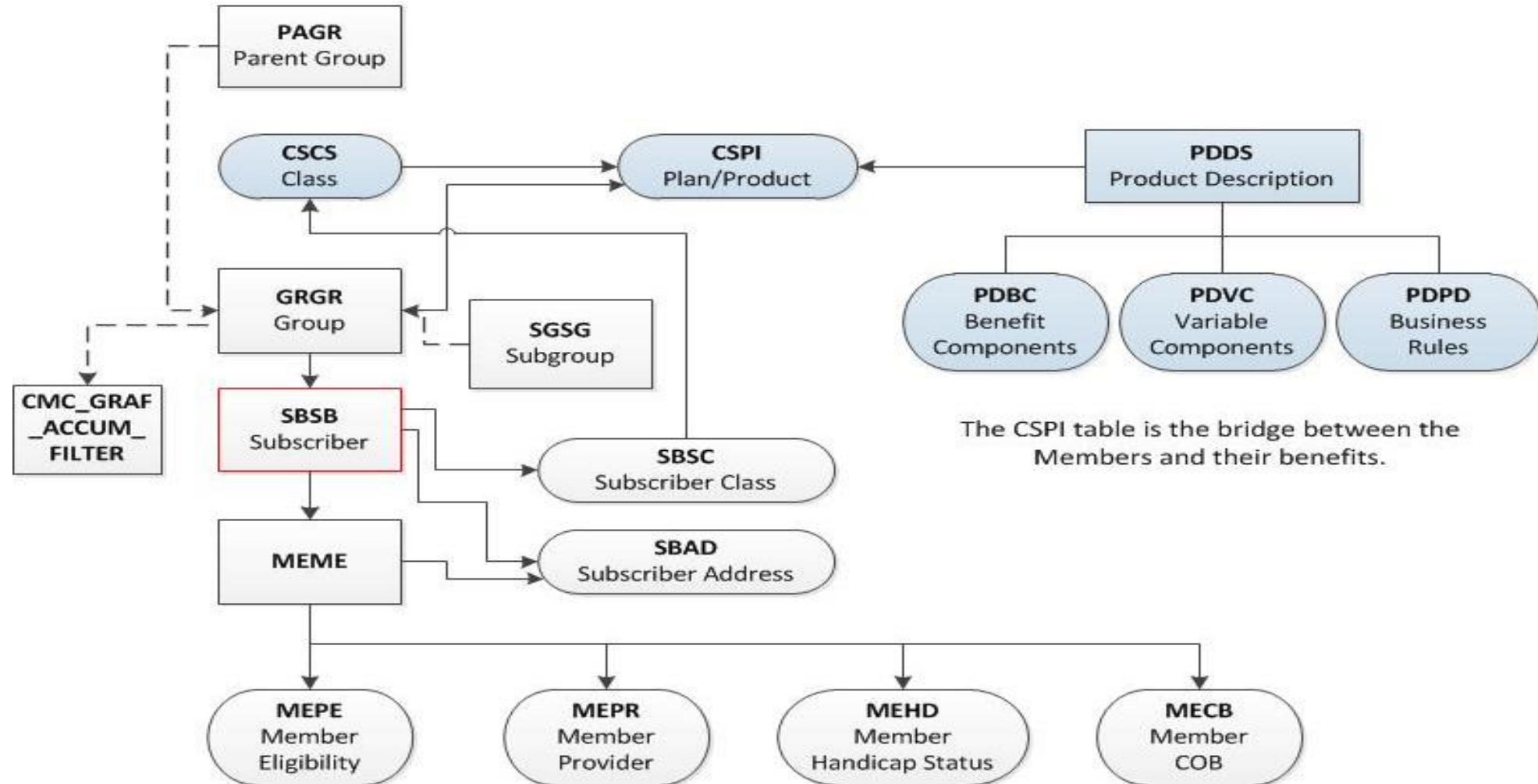
Learning Services

Agenda

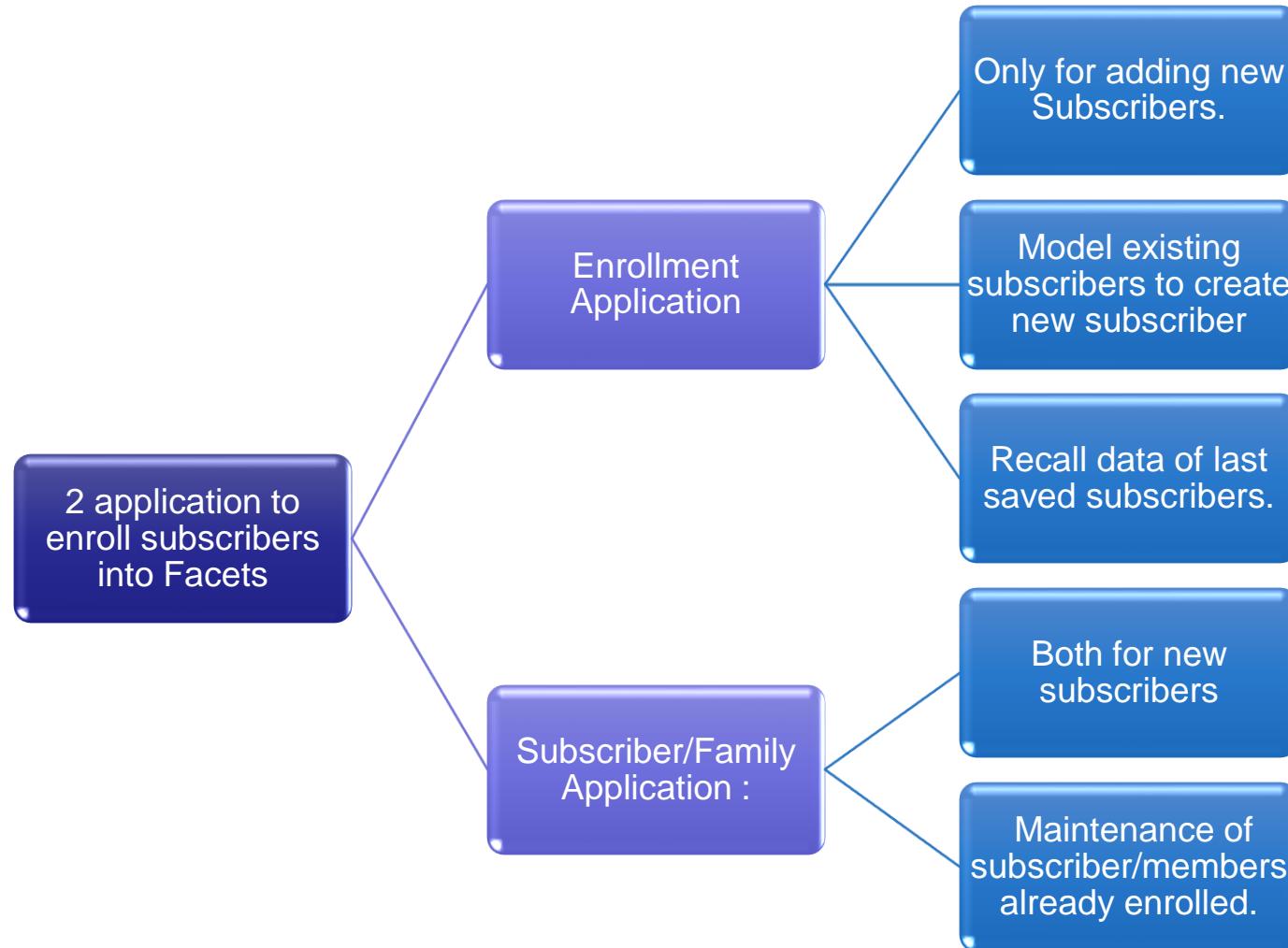
- **Subscriber**
 - Enrollment
 - Indicative details (SBSB)
 - Address (SBAD)
 - Class Relation (SBCS)
 - Subgroup Relation (SBSG)
 - Eligibility (SBEL)
 - Warning Message (SBWM)
- **Members**
 - Indicative details (MEME)
 - Address (SBAD)
 - Member Provider (MEPR)
 - Eligibility (MEEL, MEPE)
 - COB (MECB)
 - Student Details (MEST)
 - Handicap Details (MEHD)
 - Warning Message (MBWM)
- **Medicare and Medicaid Tables**
- **Eligibility**



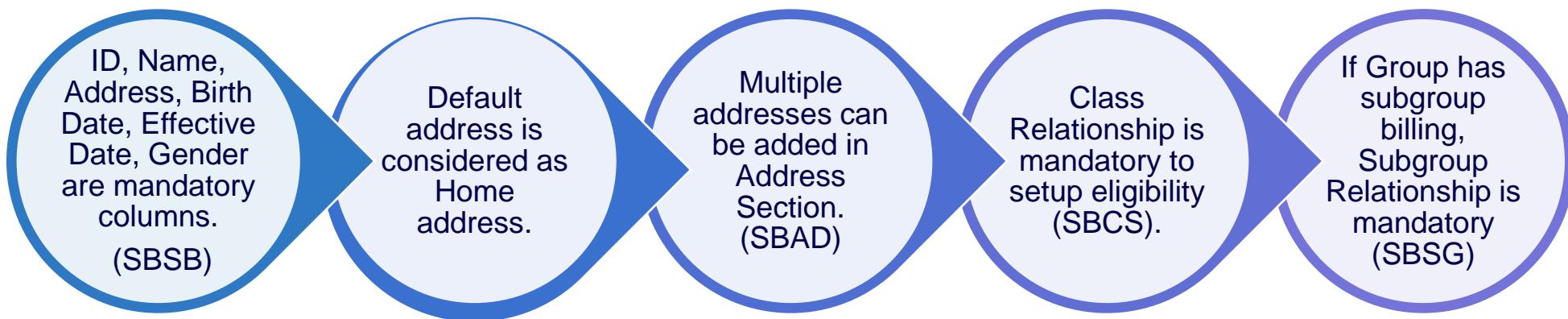
Member/ Subscriber Data Model



Subscriber



Subscriber – Contd..



Subscriber Eligibility (SBEL)

Add/Change eligibility events in Eligibility Section.

- Attach Class, Plan with Effective date

Covered Members indicate if the event is applied to all or some members.

Eligibility can be voided with Edit - > Void Event.

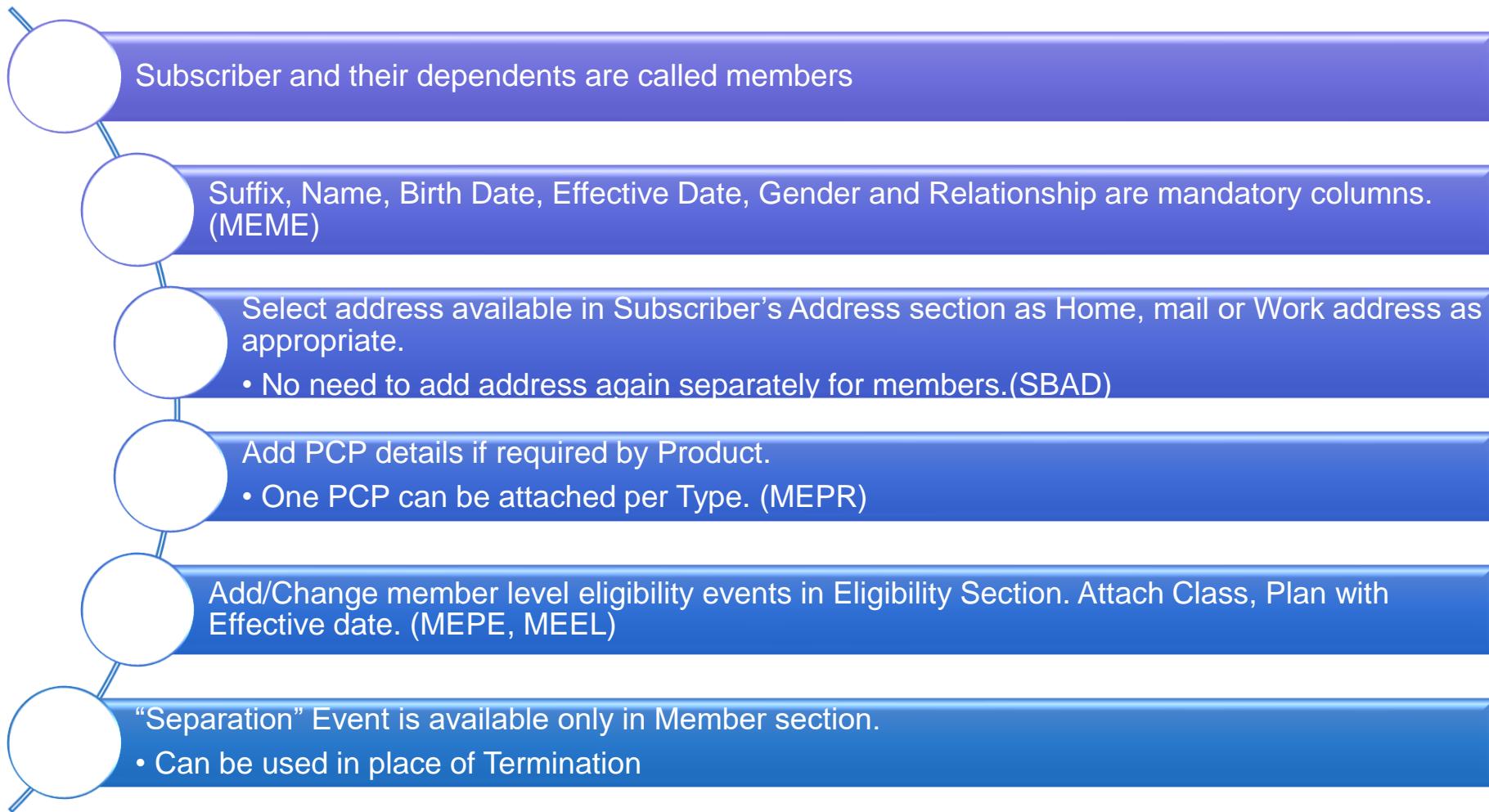
- This will make the member without having even one day of coverage.

Payment Info section holds the EFT information for Subscriber payment

User Warning Messages can be added to subscriber.

- This gets displayed up in various processing applications such as Claims, UM, Customer Service etc., (SBWM)

Members



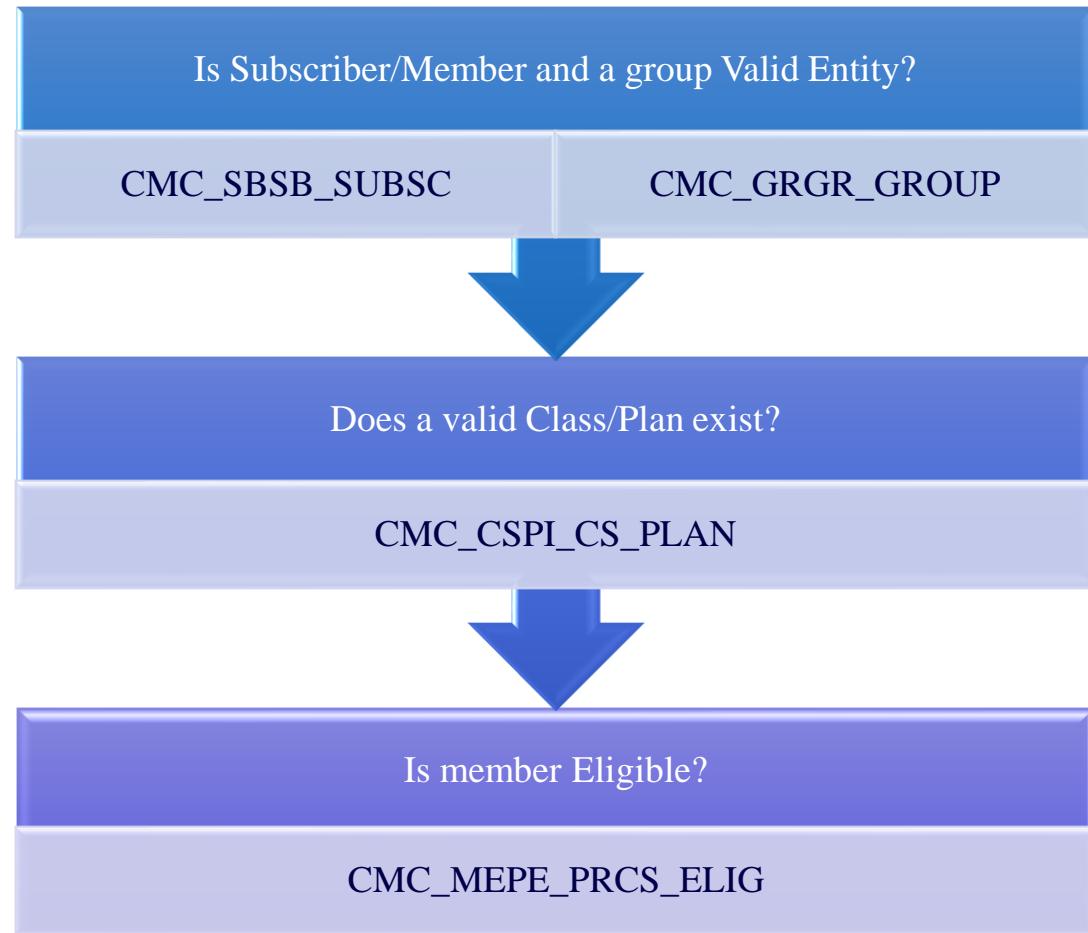
Members – Contd..

Following are some of the option sections for member.

- Conditional Eligibility
 - allows used to establish Coverage Exclusions, Pre-existing conditions, Other Party Liability and coverage extensions.
 - Plan ID, Diagnosis Code, Condition Type, Product Category and Effective date are mandatory details.
- Coordination of Benefits details are entered in COB Section. (MECB)
 - Insurance Type, Order and Carrier ID are mandatory elements.
 - Carrier ID is pre-established in Related Entity Application
- Setup Student and Handicap information of members.(MEST,MEHD))
- User Warning Messages can be added to member that shows up in various processing applications such as Claims, UM, Cust Serv etc...(MEWM)

Eligibility

Eligibility



Eligibility – Contd..

Eligibility is calculated based on

- Group Effective Date
- Subgroup Effective Date
- Class/Plan and Product Effective Date
- Subscriber Effective Date
- Member Effective Date
- Effective dates of Class and Subgroup relation with Subscriber
- Effective dates of events added at Subscriber and Member Level
- Stop Ages/Waiting Period ID's

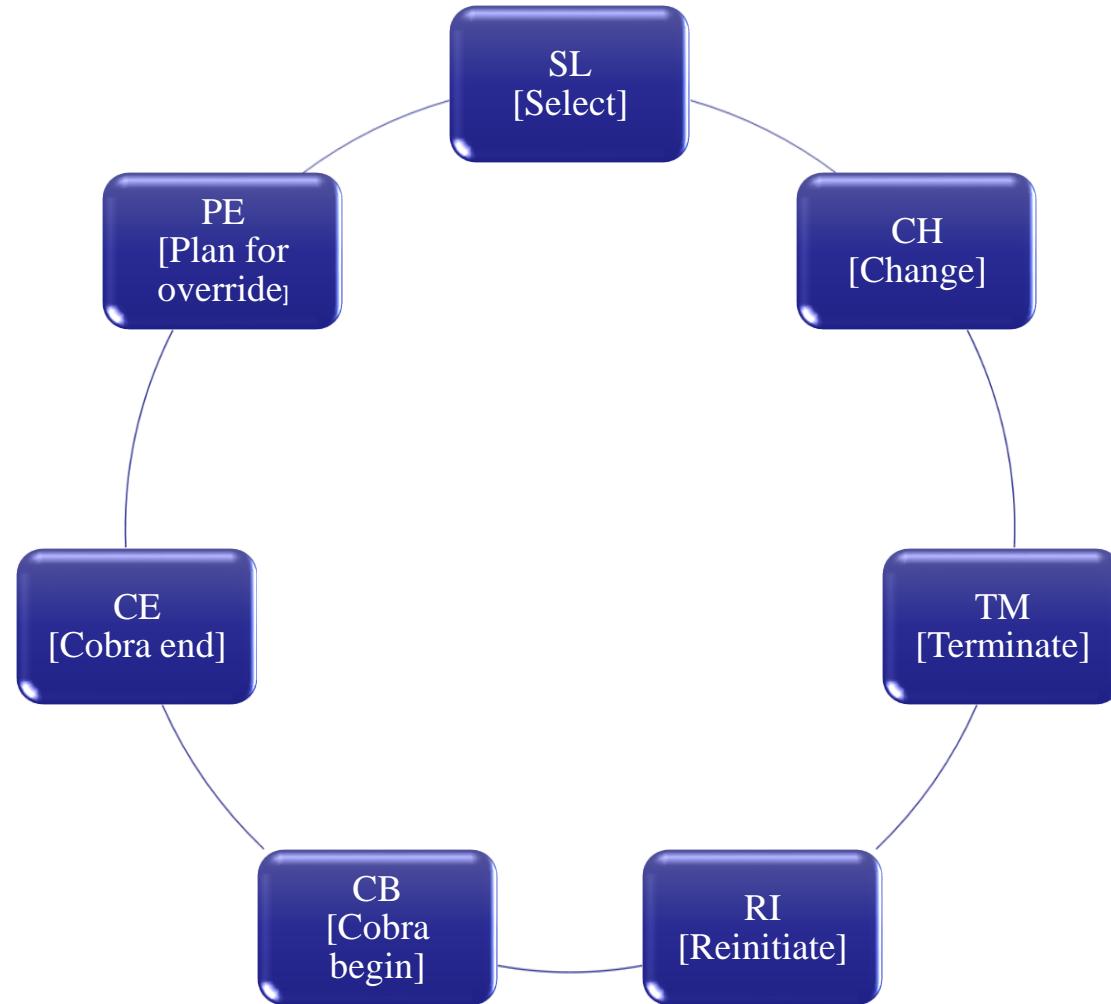
Eligibility Inquiry tab displays the eligibility details of all member under the subscriber

The period during which “Eligible” value is set as “Yes” is considered the benefit coverage period of member

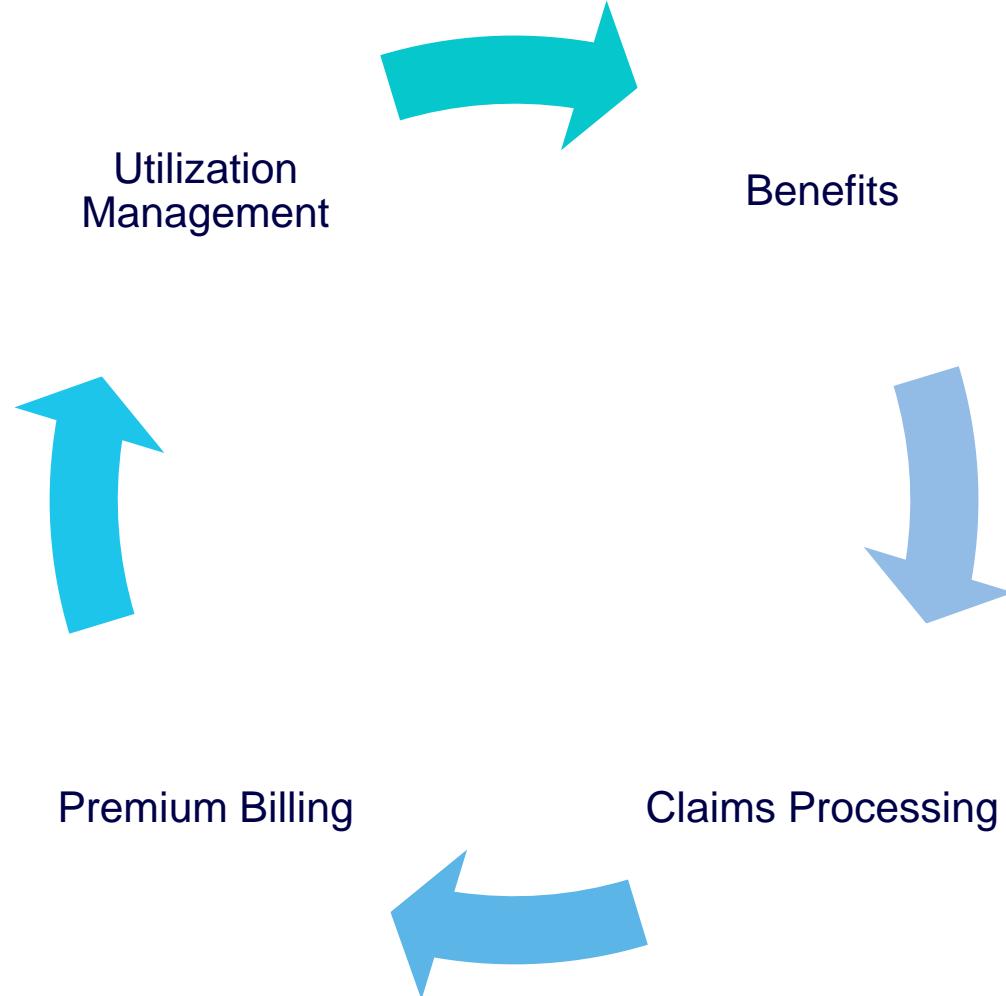
Eligibility – Contd..

The Eligibility Routine looks in...	for...
Stop Ages/Waiting Periods for the Plan	Stop Ages for Subscribers Stop Ages for Dependents Stop Ages for Students Waiting Period
Group or Subgroup	Group termination date Subgroup termination date Paid-through processing
Plan	Plan Effective Date Plan Termination Date
Subscriber/Member application	Processing Status on Hold HIPAA Selection, Change, Termination COBRA

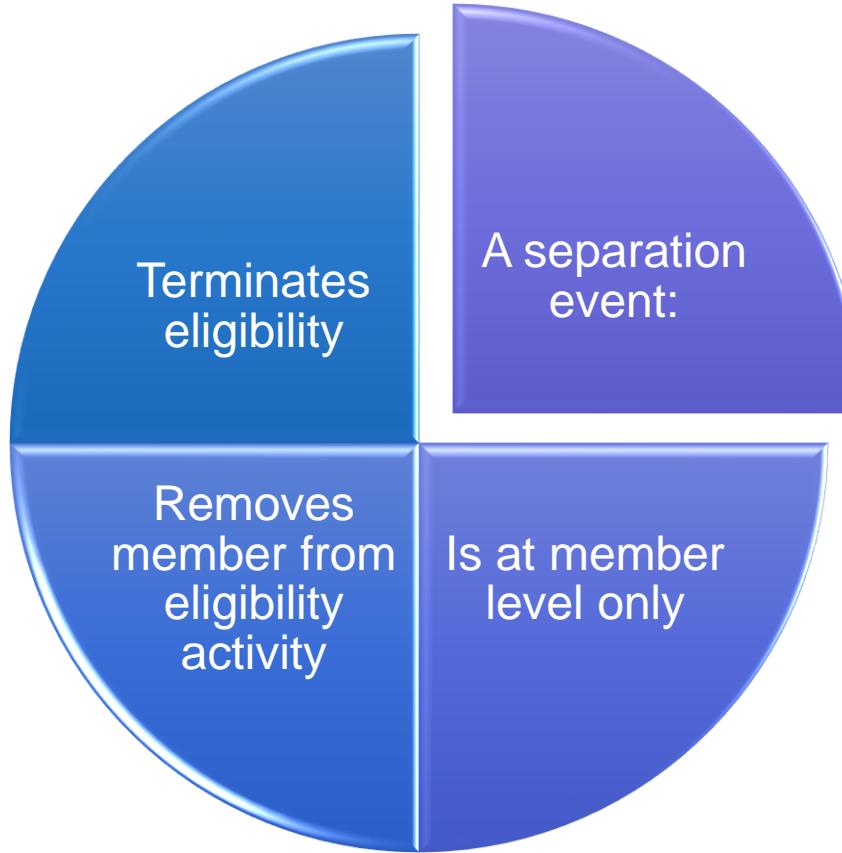
Eligibility Change Events



Member Eligibility



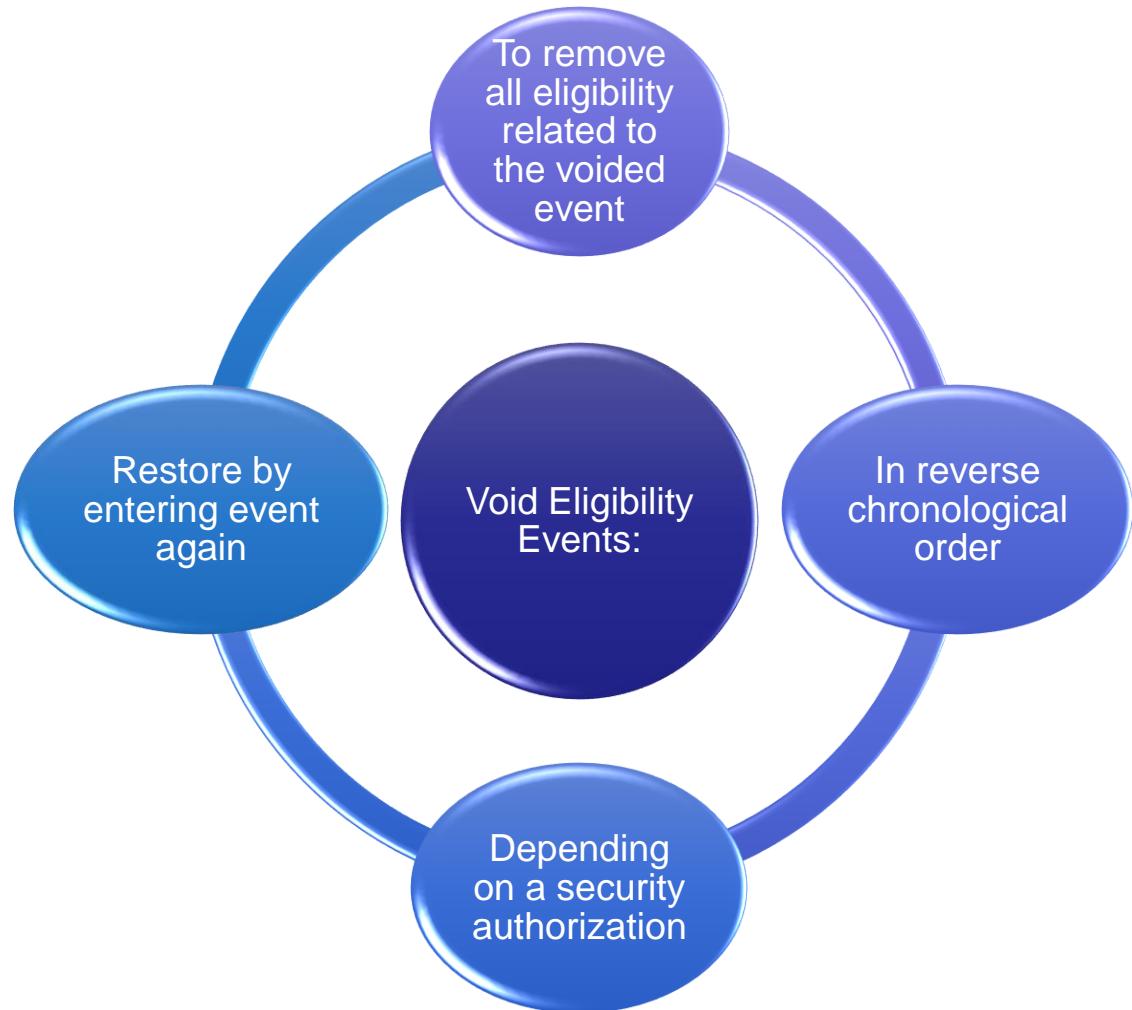
Member Eligibility Separation



Eligibility Termination



Void Event





Questions?



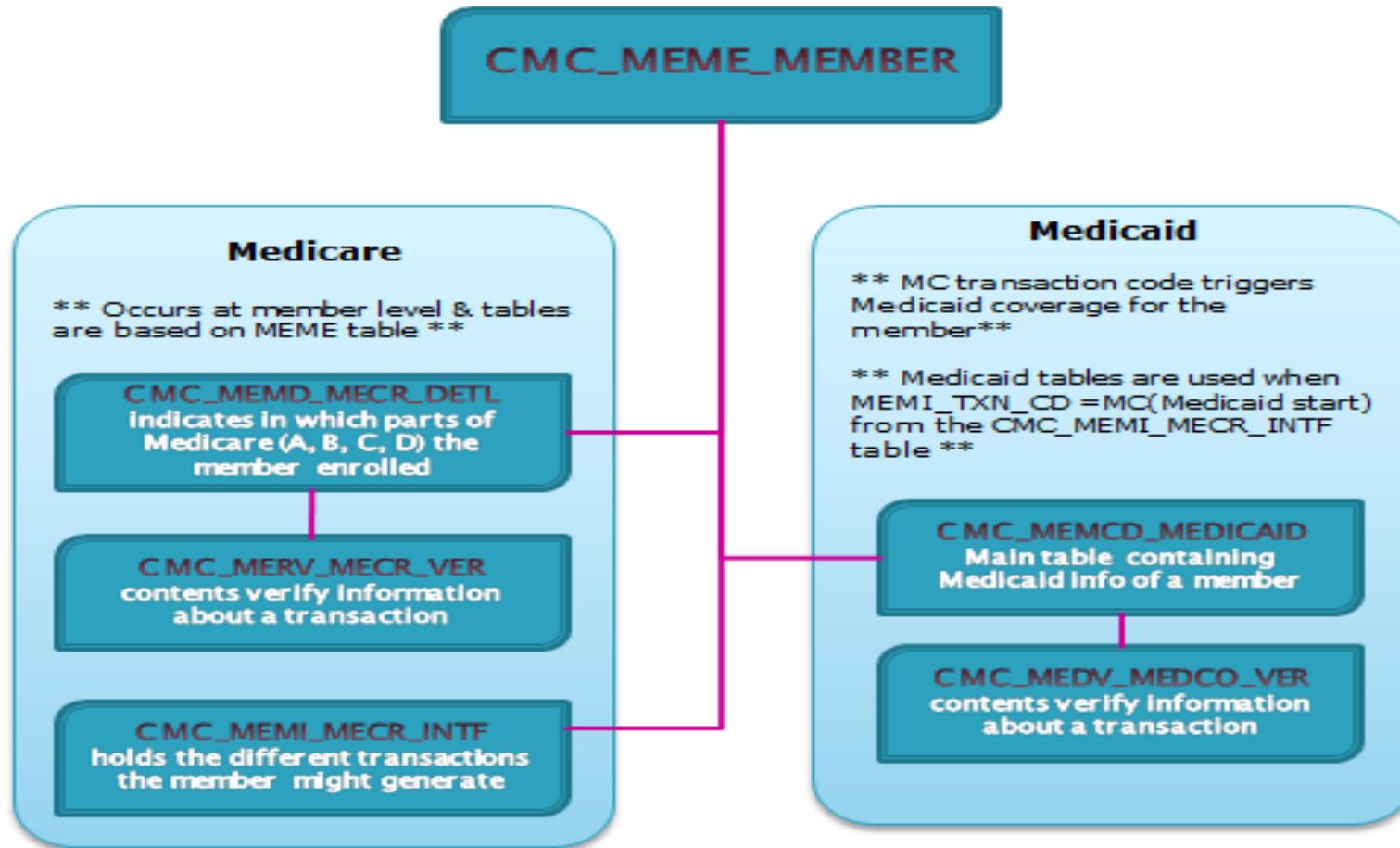
Thank you

Appendix

Member Tables

Table	Description
CMC_MEBC_COB	This table stores coordination of benefits information, including the type of additional coverage, carrier ID, policy, and effective and termination dates.
CMC_MEEL_ELIG_ENT	This table stores information for each member's eligibility events including the effective date, type of eligibility event, plan and product category.
CMC_MEME_MEMBER	This table stores indicative information on the member including name, relationship, suffix, and original effective date. For a member's address information,
CMC_MEPE_PRCS_ELIG	The MEPE table is the major source for all processed eligibility information for all members in Facets. It contains contiguous historical details on each member's eligibility events: Select, Changes, Terminations, etc. MEPE determines eligibility for cl
CMC_MEPR_PRIM_PROV	This table stores the history of each member's selected primary care provider (PCP) relationships, including the effective and term dates of the member's relationship with the provider, the PCP type (Medical Primary (MP), Medical Gynecologist (MG))
CMC_MEST_STUDENT	This table stores information used to determine eligibility for members who are students. It stores information such as the school name, full/part-time status, verification information, and effective and term dates.
CMC_MEHD_HANDICAP	This table stores information related to a member's handicap such as type (Permanent, Temporary, In Question), description, and effective and term dates
<u>CMC_MEWM_ME_MSG</u>	Table maintains the effective dated Member warning messages

Medicare and Medicaid Tables



Tables

CMC_SBSB_SUBSC	
	SBSB CK
	GRGR_CK*
	SBSB_ID*
	SBSB_LAST_NAME*
	SBSB_FIRST_NAME*
	SBSB_MID_INIT
	SBSB_ORIG_EFF_DT*
	SBSB_MCTR_STS
	SBSB_MCTR_VIP
	SBSB_EMPLOY_ID
	SBSB_HIRE_DT
	SBSB_RETIRE_DT
	SBSB_FI*
	SBSB_PAY_CL METH*
	SBSB_TYPE_HOME*
	SBSB_TYPE_MAIL
	SBSB_TYPE_WPRL
	SBSB_LAST_NAME_XLOW*

Subscriber Indicative Table

Subscriber Warning Messages Table

Group ID	Subscriber ID	Standard Unique Health ID		
C07G0002	070700001			
-->	User Message	Effective	Termination	Termination Reason
	00001 TEST1			
	00002 TEST2			
	00003 TEST3			
	00012 Subscriber receives pharmacy benefit Not required to pay out of pocket for			
	00021 Returned mail for subscriber. Verify subscriber address.			
	00031 Subscriber on LTD			

CMC_SBWM_SB_MSG	
	SBSB CK
	SBWM EFF DT
	WMDS SEQ NO
	SBWM_TERM_DT
	SBWM_MCTR_TRSN
	GRGR_CK

Tables – Contd..

Group ID	Subscriber ID	Standard Unique Health ID
C07G0002	070700001	
Group ID	Subgroup ID	Subgroup Name
C07G0002	C071	Eclipse Denver Bell Company

Group C07G0002 Eclipse Corporation
Subgroup C071 Eclipse Denver Bell Company
Effective Date 01/01/2007
Termination Date

Subscriber Relationship Table

Subscriber Class Information Table

Group ID	Subgroup ID		
C07G0002	C071		
	Class ID	Effective	Termination
-->		▼	▲
	C071	Local 792 Union Class	
	C072	Internship / Special / Temporary Employees Class	
	C073	Executive Employees	
	C081	Executive Class for Training	
	COBR	COBRA Class	
	SD01	Steven's Full-Time Class	

CMC_SBSG_RELATION	
KEY	<u>SBSB CK</u>
KEY	<u>SBSG EFF DT</u>
	GRGR_CK
	SGSG_CK
	SBSG_TERM_DT
	SBSG_MCTR_TRSN

CMC_SBCS_CLASS	
KEY	<u>SBSB CK</u>
KEY	<u>SBSG EFF DT</u>
	SBCS_TERM_DT
	GRGR_CK
	CSCS_ID

Tables – Contd..

Subscriber Eligibility Table

Group ID	Subscriber ID	Standard Unique Health ID
C07G0002	070700001	

Date	Category	Event	Plan ID	Void Event
01/01/2013	Medical Product	Select	C07PPOA	N

Eligibility Event

Eligibility Date 01/01/2013	Event Select	Family Indicator Family
Category Medical Product		
Plan ID C07PPOA	Rate Member As	
PPO Advantage Health Plan		
Selection Override Reason		
Explanation	Reason	
<input type="button" value="OK"/> <input type="button" value="Cancel"/> <input type="button" value="Search"/> <input type="button" value="Help"/>		

Category
M Medical Product

Covered Members
A Family

Plan ID
C07PPOA PPO Advantage Health Plan

Rate Member As
Determined From Eligibility Events

Explanation

Reason

CMC_SBEL_ELIG_ENT	
 SSBCK	 SBEL_EFF_DT
 SBEL_INSQ_DT	GRGR_CK
	SBEL_ELIG_TYPE
	CSPD_CAT
	CSPI_ID
	SBEL_FI
	EXCD_ID
	SBEL_MCTR_RSN
	SBEL_VOID_IND
	SBEL_MCTR_ORSN

Tables – Contd..

Member Eligibility Table

The screenshot shows a software application window titled "Member Eligibility Table". At the top, there is a grid with columns for "Name", "Relationship", and "Birth Date". The "Relationship" column contains "Subscriber", "Wife", and "Son" for the respective rows. The "Birth Date" column shows dates: 05/01/1954, 01/22/1957, and 08/17/1987. Below the grid are buttons for "Terminate Member" and "Cancel Coverage". A navigation bar at the bottom includes tabs like "Indicative", "Address Select", "PCP", "Eligibility", "HRA Accum", "Condit. Elig.", "Rating Override", "COB", "Other Carrier", "Handicap", and "Stude".

A modal dialog box titled "Eligibility Event" is open in the foreground. It contains fields for "Eligibility Date" (set to 01/01/2006), "Event" (dropdown menu), "Category" (dropdown menu), "Plan ID" (dropdown menu), and "Rate Member As" (dropdown menu). There is also a section for "Selection Override Reason" with a dropdown menu, and "Explanation" and "Reason" dropdown menus. At the bottom are buttons for "OK", "Cancel", "Search", and "Help".

To the right of the main window, there is a vertical list of table names enclosed in a box with an orange border:

- CMC_MEEL_ELIG_ENT
- MEME_CK
- MEEL_EFF_DT
- MEEL_INSQ_DT
- GRGR_CK
- MEEL_ELIG_TYPE
- CSPD_CAT
- CSPI_ID
- EXCD_ID
- MEEL_MCTR_RSN
- MEEL_VOID_IND
- MEEL_MCTR_ORSN

Tables – Contd..

Group ID	Subscriber ID	Standard Unique Health ID			Notes Exist	
Mem Sfx	From	Through	Eligible	Subgroup	Plan	Product
01		12/31/2005	No		C07PPOA	C07PPP01
01	01/01/2006	01/31/2006	No	C070	C07PPOA	C07PPP01
01	02/01/2006	01/31/2022	Yes	C070	C07PPOA	C07PPP01
01	02/01/2022		No	C070	C07PPOA	C07PPP01
01	01/01/2006	12/31/2005	No		C07DENT	C07DAP01
01	01/01/2006	01/31/2006	No	C070	C07DENT	C07DAP01
01	02/01/2006	01/31/2022	Yes	C070	C07DENT	C07DAP01
01	02/01/2022		No	C070	C07DENT	C07DAP01
01	01/01/2006	12/31/2005	No		C07VIS	C07VAP01
01	01/01/2006	01/31/2006	No	C070	C07VIS	C07VAP01
01	02/01/2006	12/31/2011	Yes	C070	C07VIS	C07VAP01
01	01/01/2012		No	C070	C07VIS	C07VAP01
01	01/01/2006	12/31/2005	No		C11STD01	C11STD01
01	01/01/2006	12/31/2009	No	C070	C11STD01	C11STD01
01	01/01/2010		No	C070	C11STD01	C11STD01
02	01/01/2006	12/31/2005	No		C07PPOA	C07PPP01
02	01/01/2006	01/31/2006	No	C070	C07PPOA	C07PPP01
02	02/01/2006	08/31/2006	Yes	C070	C07PPOA	C07PPP01
02	09/01/2006	08/31/2010	Yes	C070	C07PPOA	C07PPP01
02	09/01/2010	12/31/2011	No	C070	C07PPOA	C07PPP01

Member Name	Relationship	Gender	Birthdate
Carucci	Carmela	Wife	Female 01/22/1957
Class	C071 Local 792 Union Class		
Product Category	Medical Product		
Covered Members	Family		
Plan	PPO Advantage Health Plan		
Product	PPO Advantage Product		
Plan Entry Date	02/01/2006	Eligibility Selection Level	Subscriber
Subgroup	Eclipse New York Bell Company		
Explanation			
Reason			

Member Eligibility Table

CMC_MEPE_PRCS_ELIG	
	MEME CK
	CSPD CAT
	MEPE EFF DT
	MEPE_TERM_DT
	MEPE_CREATE_DTM
	CSCS_ID
	GRGR_CK
	SGSG_CK
	CSPI_ID
	PDPD_ID
	MEPE_ELIG_IND
	EXCD_ID
	MEPE_MCTR_RSN
	MEPE_FI

Tables – Contd..

Group ID C07G0002	Subscriber ID 070700003	Standard Unique Health ID	Notes Exist												
<table border="1"><thead><tr><th>Name</th><th>Relationship</th><th>Birth Date</th></tr></thead><tbody><tr><td>Carucci, Antonio</td><td>Subscriber</td><td>05/01/1954</td></tr><tr><td>Carucci, Carmela</td><td>Wife</td><td>01/22/1957</td></tr><tr><td>Carucci, Anthony</td><td>Son</td><td>08/17/1987</td></tr></tbody></table>				Name	Relationship	Birth Date	Carucci, Antonio	Subscriber	05/01/1954	Carucci, Carmela	Wife	01/22/1957	Carucci, Anthony	Son	08/17/1987
Name	Relationship	Birth Date													
Carucci, Antonio	Subscriber	05/01/1954													
Carucci, Carmela	Wife	01/22/1957													
Carucci, Anthony	Son	08/17/1987													
<p>Terminate Member Cancel Coverage</p> <p>Indicative Address Select PCP Eligibility HRA Accum Condit. Elig. Rating Override COB Other Carrier Handicap Student</p> <p>PCP</p> <p>PCP ID: C07000001101 Name: Andersen, Morgan A. OK Cancel</p> <p>Related Entity</p> <p>Related Entity ID Value Help</p> <p>PCP Type: MP Effective Date: 01/01/2006</p> <p>Selection Override Reason Manual Assignment Reason</p> <p>Termination Date Termination Reason</p>															

Member PCP Table

CMC_MEPR_PRIM_PROV	
	MEME CK
	MEPR PCP TYPE
	MEPR EFF DT
	MEPR_TERM_DT
	MEPR_MCTR_TRSN
	MEPR_MCTR_ORSN
	MEPR_MCTR_ERSN
	GRGR_CK
	PRPR_ID
	MEPR_SOURCE
	MEPR_DEMGRPHC_IND
	MEPR_CAP_REL_ENT

Tables – Contd..

Member COB

Insurance Type	Commercial - Medical	Order	Primary
Carrier ID	OXFORD	Oxford Trust Health Plan	
Policy	C07OX74384		
Claim LOI Start Date			
Effective Date	01/01/2006	Termination Date	
Termination Reason			
Medicare/Part D Supplemental Data			
Supplemental Drug Type			
Medicare Secondary Payer Type			
Prescription Drug Coverage Type			
RX Group		RX ID	
RX BIN		RX PCN	
Primary COB Policyholder			
Last Name	Carucci	First Name	Carmela
ID	C07OX74384		
Last Verification			
Verified By	kelleyd		
Date	01/10/2010		
Method	LETT		

Member COB Table

CMC_MECB_COB	
MEME CK	
MECB INSUR TYPE	
MECB INSUR ORDER	
MECB MCTR STYP	
MECB EFF DT	
MECB_TERM_DT	
MECB_MCTR_TRSN	
GRGR_CK	
MCRE_ID	
MECB_POLICY_ID	
MECB_MCTR_MSP	
MECB_RXBIN	
MECB_LAST_VER_DT	
MECB_MCTR_VMTH	



Facets – Providers

Provider Types and Provider Network Configurations

Learning Services

Agenda

- Providers and different Provider Types
- Configure Common Practitioner and Practitioner
- Provider Address types
- Provider Related entity and the hierarchy
- Network-Provider Structure
- Network-Provider Process Flow
- Provider Date Sensitivity
- Provider Credentialing

Provider

In Facets, 'provider' is an all-encompassing term referring to any entity that provides health care related services to members.



Definitions

Common Practitioner (PRCP)

Common Practitioner is a Facets term for the provider record that contains the basic indicative information about the contracted practitioner.

Practitioner (PRPR where PRPR_ENTIT Y = P)

A practitioner is an individual (physician, nurse practitioner, social worker, etc.) who provides health care services.

Definitions – Contd..

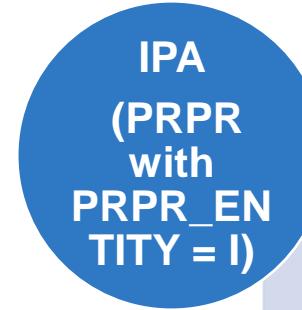


A facility is an institution that provides medical services (hospital, long term care center, pharmacy, etc.).

Some health plans allow facilities to act as Primary Care Physicians

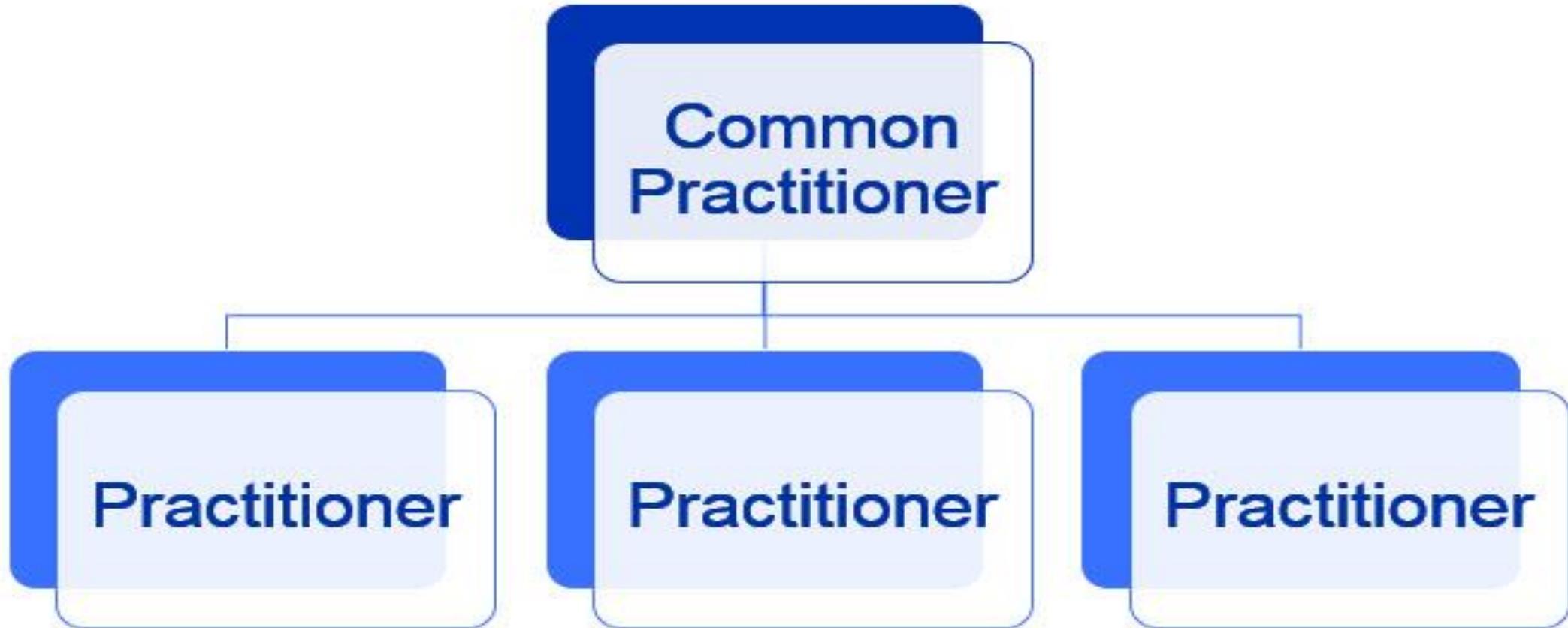


If providers are in groups, it usually means that they have joined together under one Tax ID for the purpose of providing services

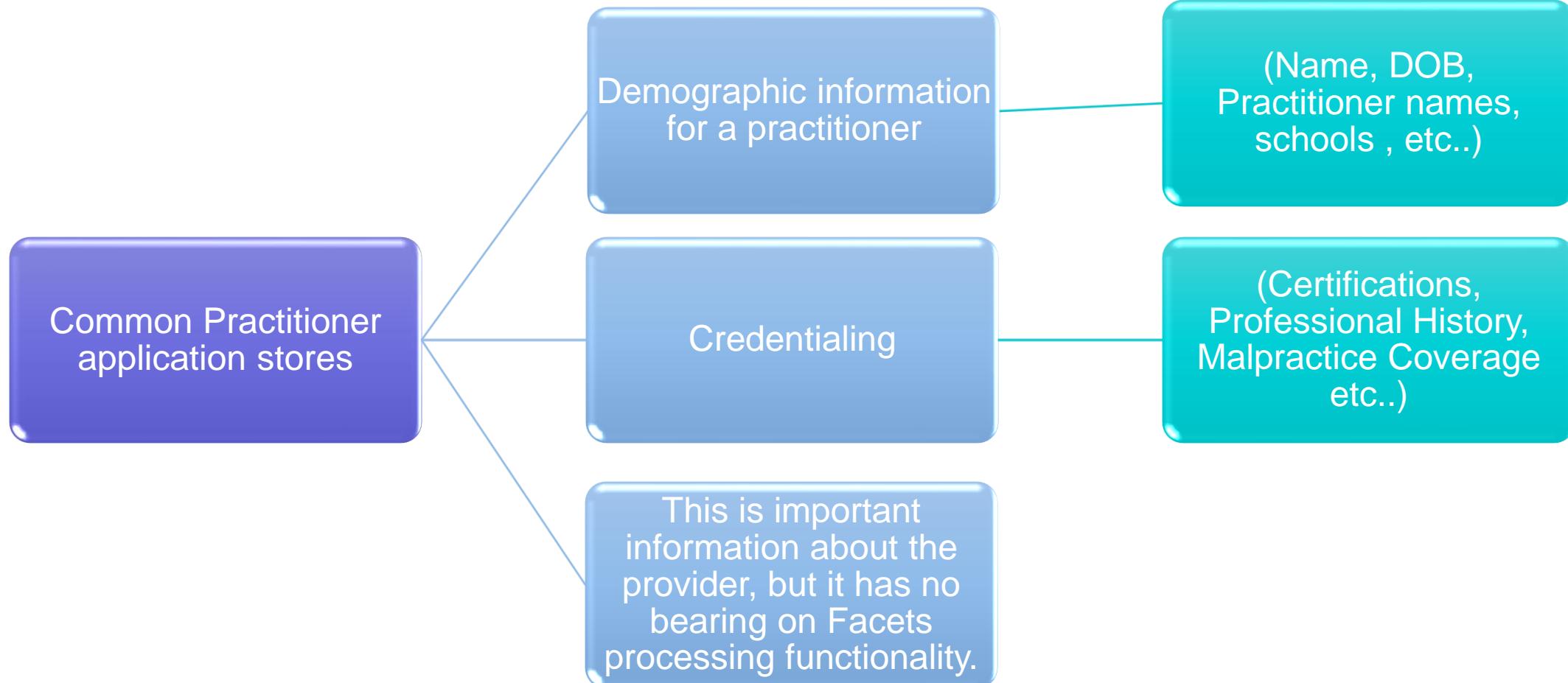


An IPA (Individual Physician Association) is an entity that contracts with individual providers and groups to provide health care services for health plan members for negotiated fees.

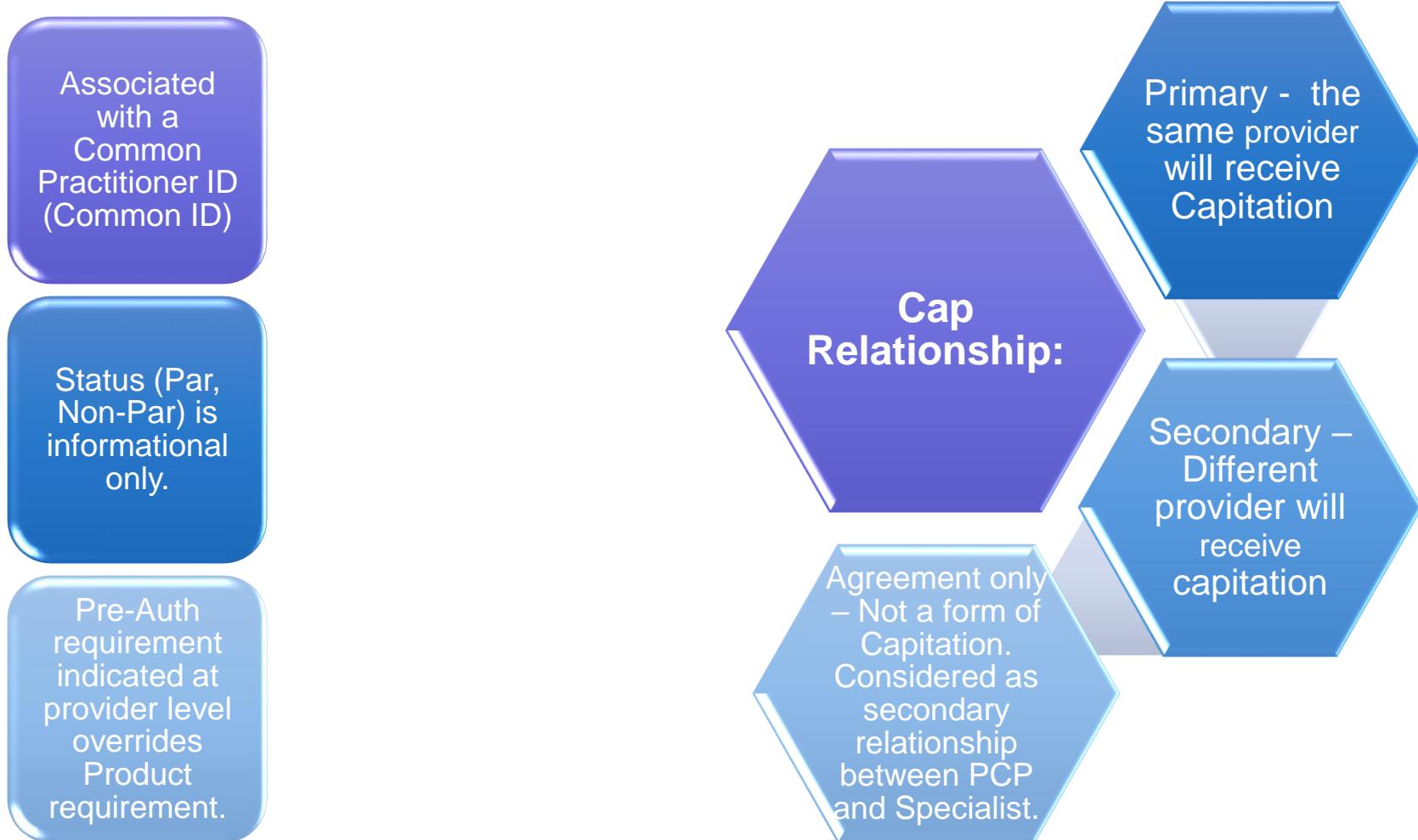
Provider Records Concepts in Facets



Setting up Common Practitioners



Practitioner



Practitioner – Contd..

Primary Address

- **Mandatory** - You must designate one address as the primary address by selecting the Primary check box on the Indicative section tab.
- **Only one effective record** - Facets allows only one address type to be designated as the Primary address for a provider. The Primary address must also be a practice location.
- Used for Zip code based pricing
- The Primary address is the default address for many Facets applications, such as Case Management and Customer Service.

Remittance Address

- **Mandatory** - You must designate one address as the primary address. select the Remit check box on the Indicative section tab.
- **Only one effective record** - Only one address location can be designated as the remittance address for a provider;
- Only checks and remittances go to this location; all other mail goes to other designated addresses.

Practitioner – Contd..

Practice Address

- A Provider can have multiple practice addresses.

Mailing Address

- When you select an address as a Practice location, Facets automatically displays the address Type in the Mail address type field on the Indicative section tab, meaning that all letters (but not checks) for that Practice location will be sent to that address.
- You can designate a different address as the mailing address for a Practice location.

Practitioner – Contd..

Payment Info

To whom Claim or Cap Payment will be made

EFT details (Optional)

How to combine check payments.

Tax Information

Tax number for 1099 reporting.

User Warning Messages

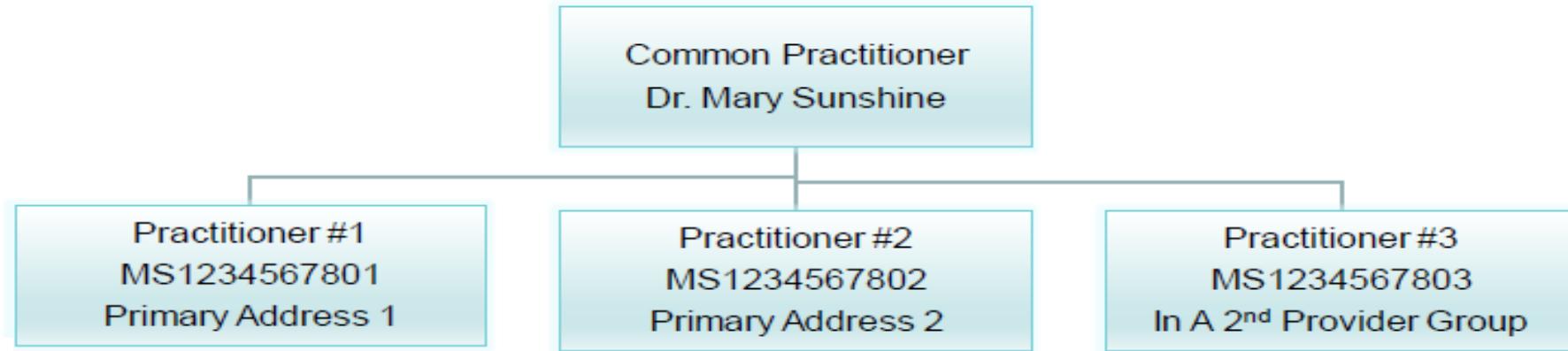
Like SBSB & MEME, Warning messages can be attached to Providers.

Shows up in Customer Service, UM , Claims etc..

Claims Pay Hold

Similar to Group, Subgroup, Member, Claim payment can be held for Provider as well

Common Practitioner vs. Practitioner



- * **Different primary addresses effective at the same time**
- * **In more than one Provider Group at the same time**
- * **In more than one IPA at the same time**
- * **Multiple effective Tax IDs**
- * **Multiple specialties**
- * **Sponsors a numbers of providers at the same time**
- * **Multiple network provider relationships effective at the same time for specific plans**
- * **Effective in multiple networks within the same plan (Network Set set-up)**

Common Practitioner vs. Practitioner – Contd..

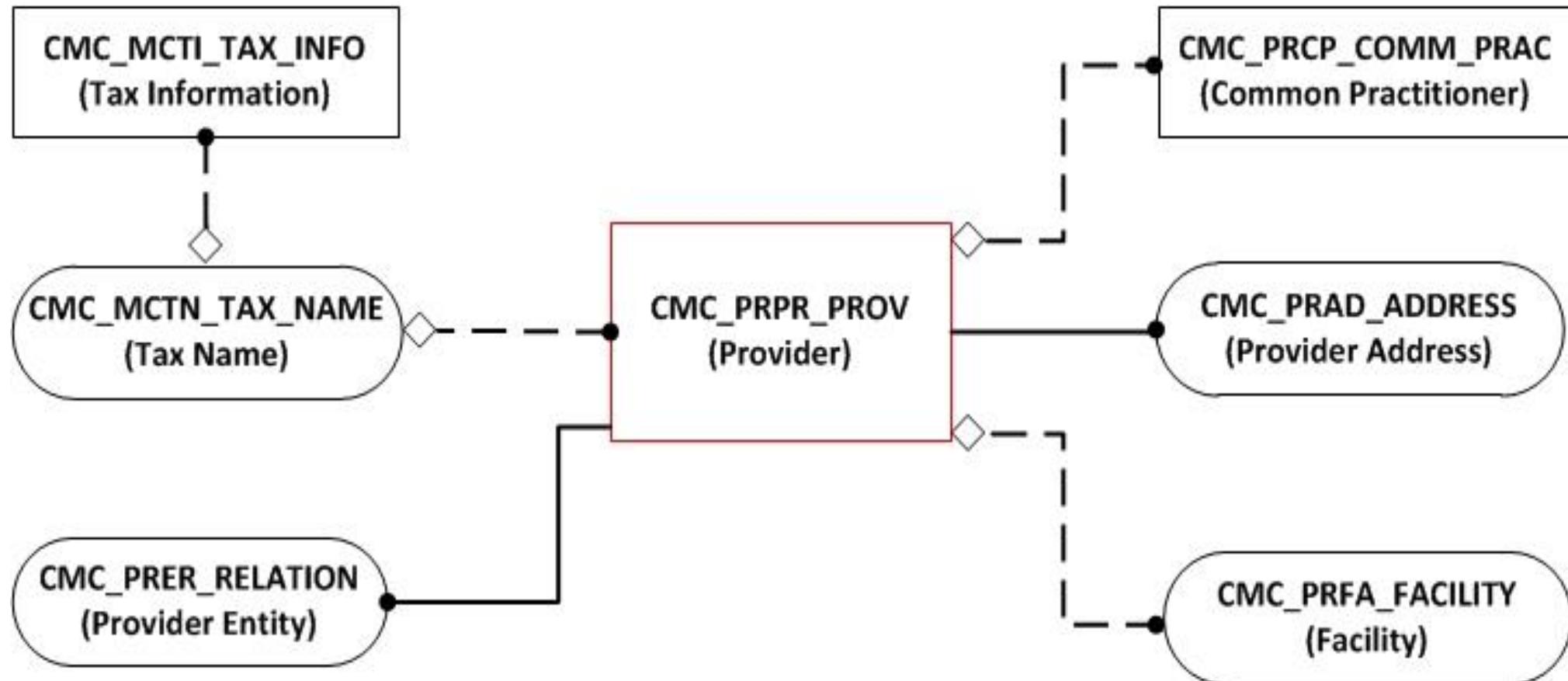
► Common Practitioner

- Holds static information:
 - Name
 - Birth Date
 - Gender
 - SSN
 - Malpractice Insurance
 - Education
 - Etc.

► Practitioner

- Holds dynamic information:
 - Addresses
 - Provider Relationships
 - Network Affiliations
 - Tax Info
 - Etc.

Provider Structure

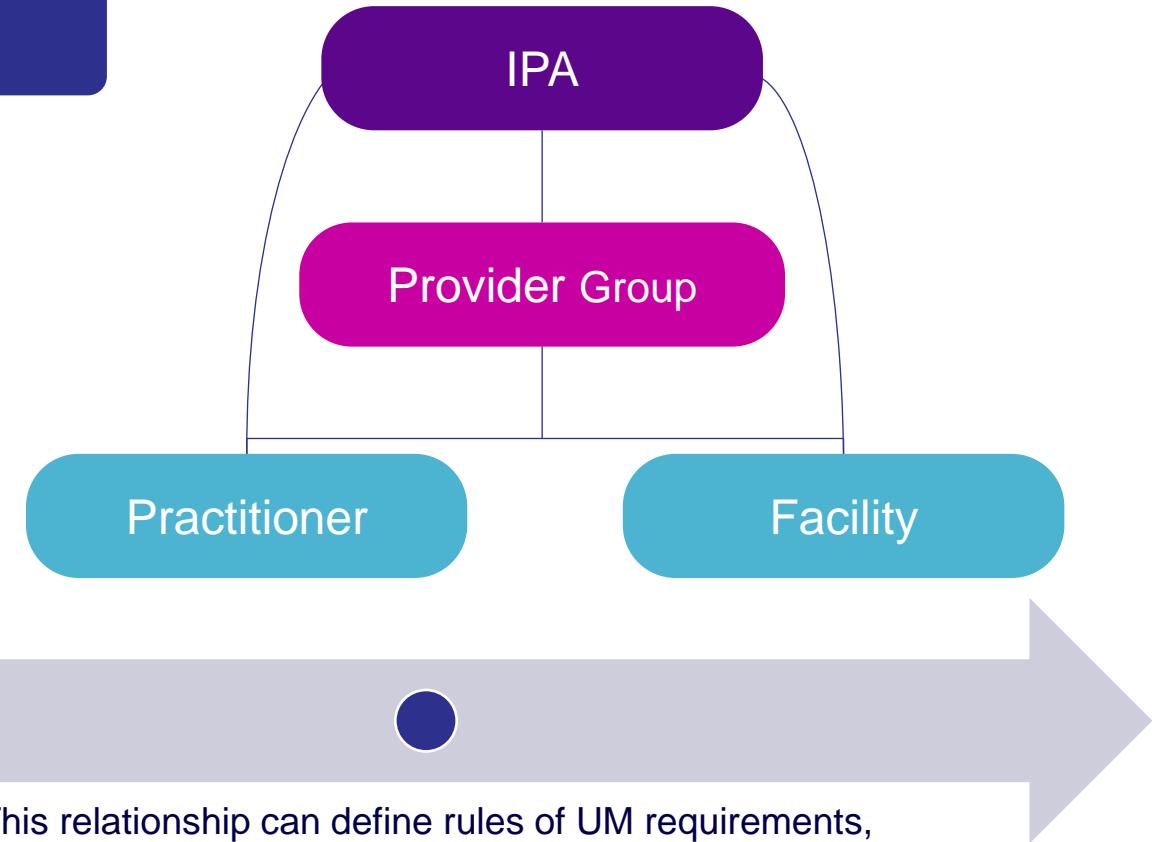


Provider Entity Relationship

4 Provider Types

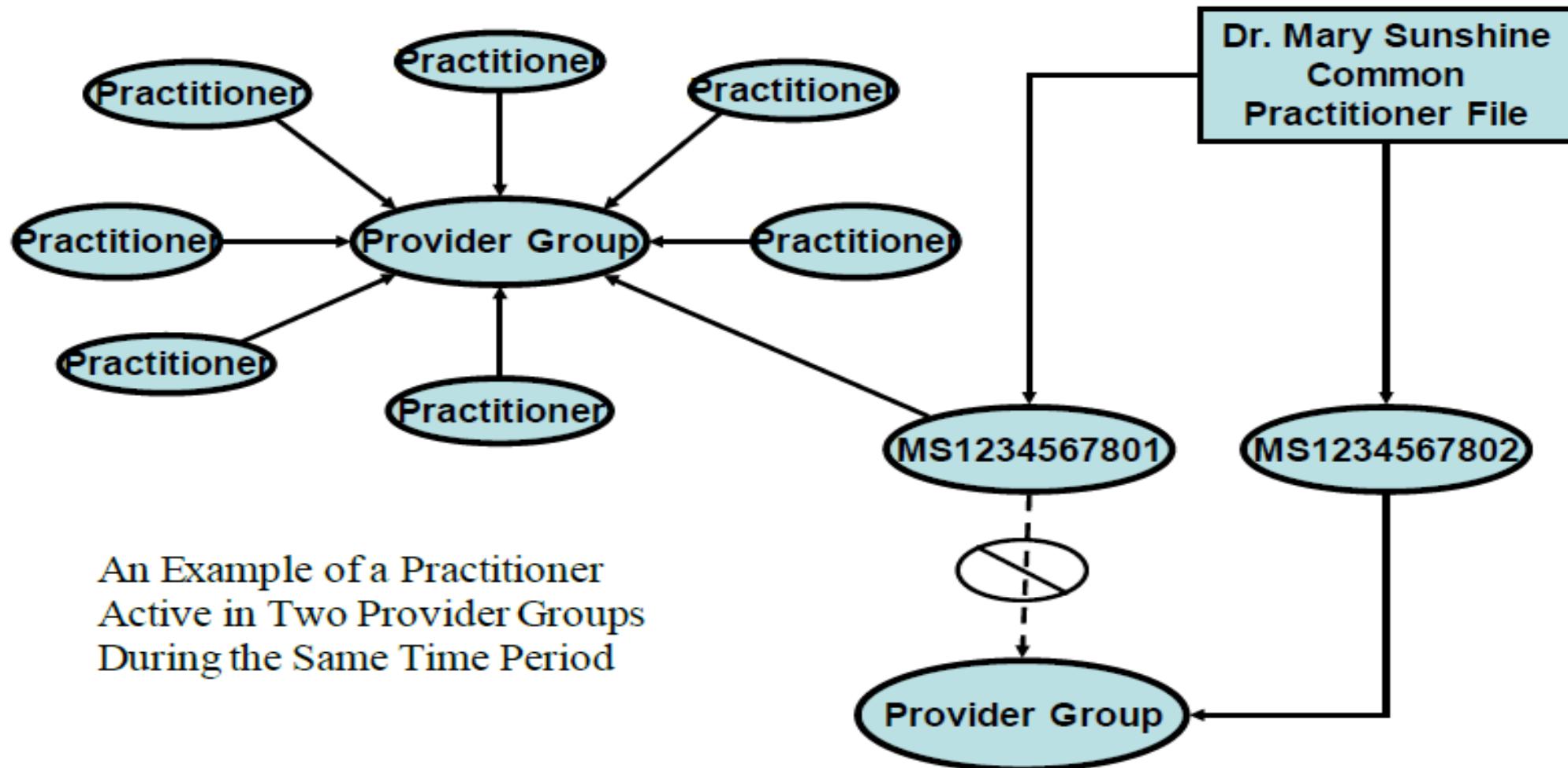
- Independent Practice Association (IPA)
- Provider Group
- Practitioner
- Facility

Facets defines a provider's relationship to other providers for claims and reviews as a provider related entity relationship (PRER)



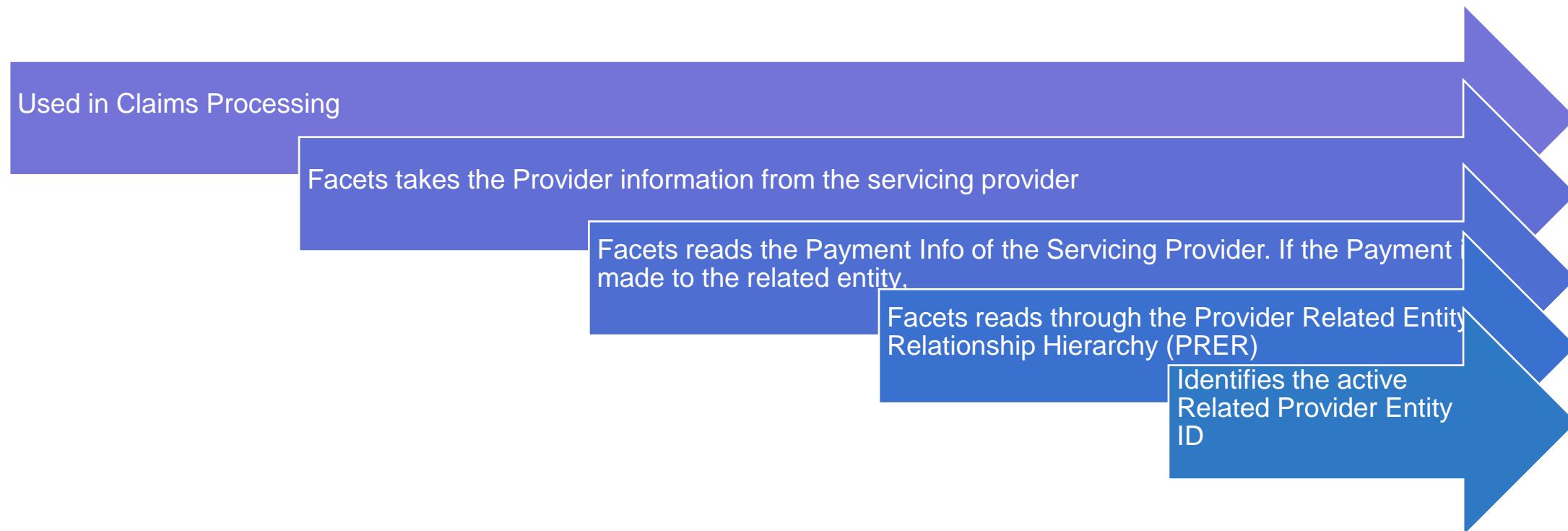
This relationship can define rules of UM requirements, and affect channeling results and inclusion in provider directories. In addition, provider entity relationships affect address sharing and payment information

Practitioner – Provider Group Relationship

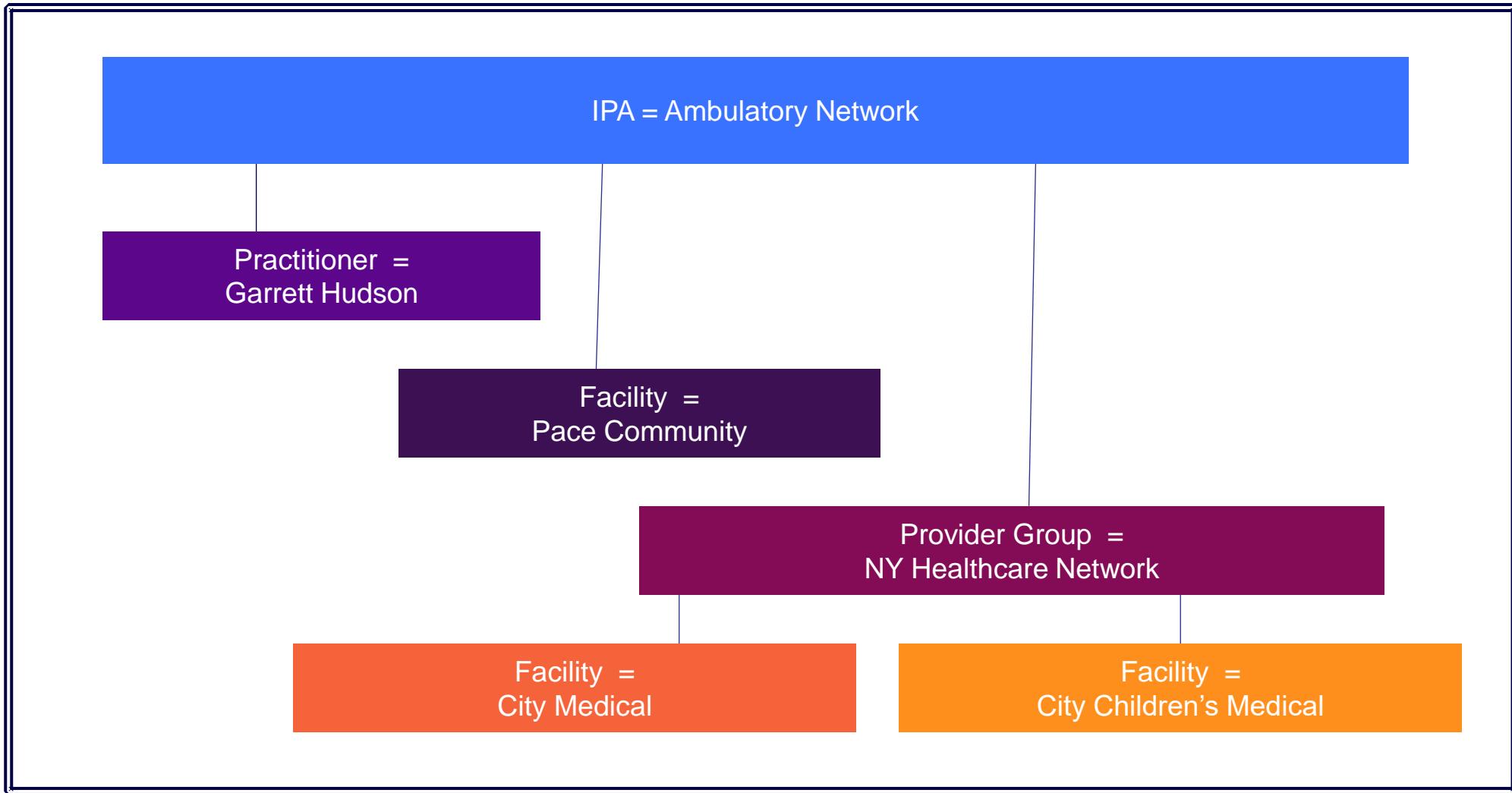


An Example of a Practitioner
Active in Two Provider Groups
During the Same Time Period

Provider Entity Relationship



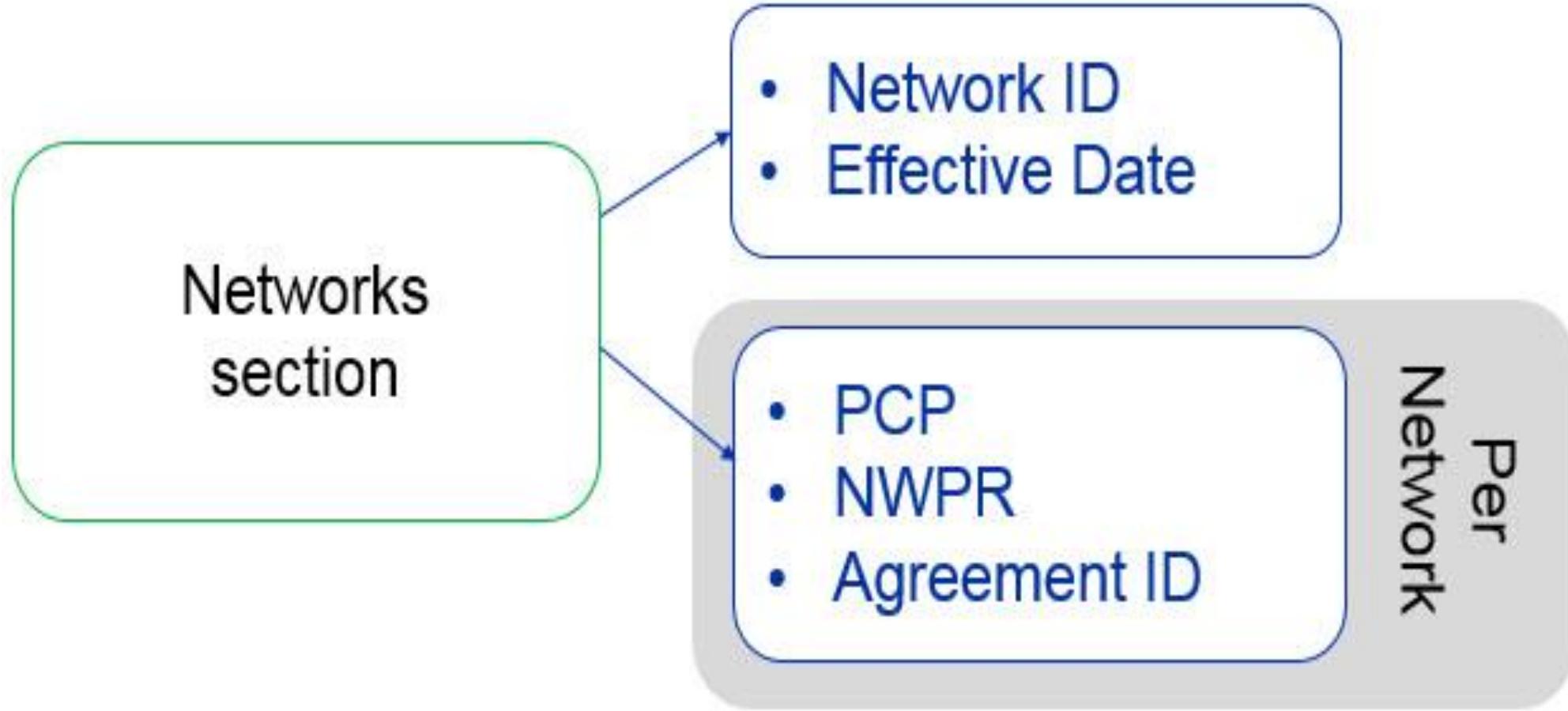
Provider Entity Hierarchy



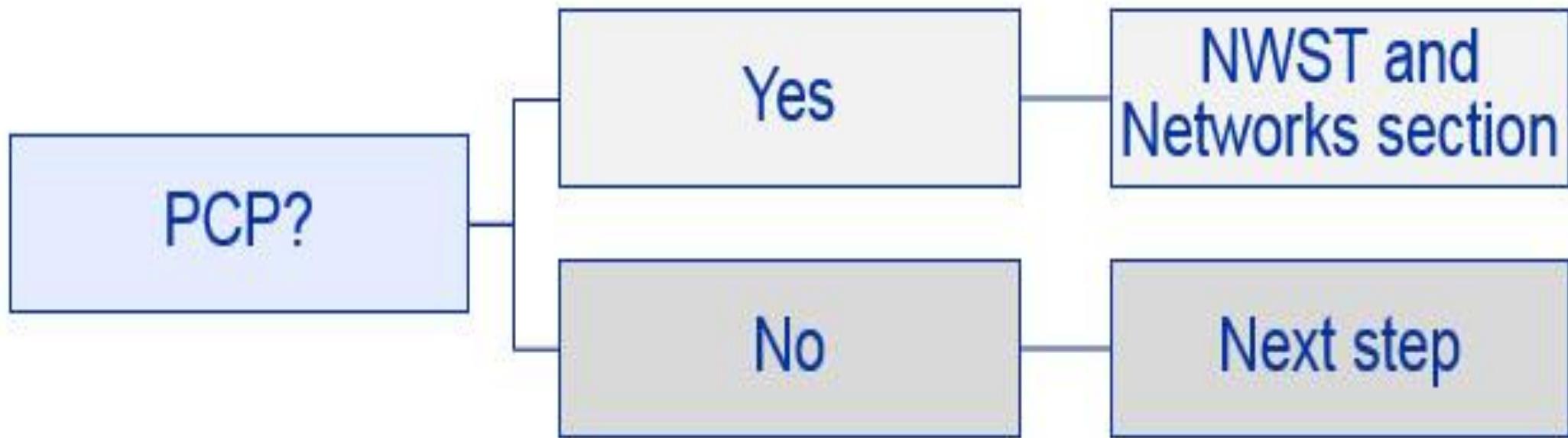


Provider Network

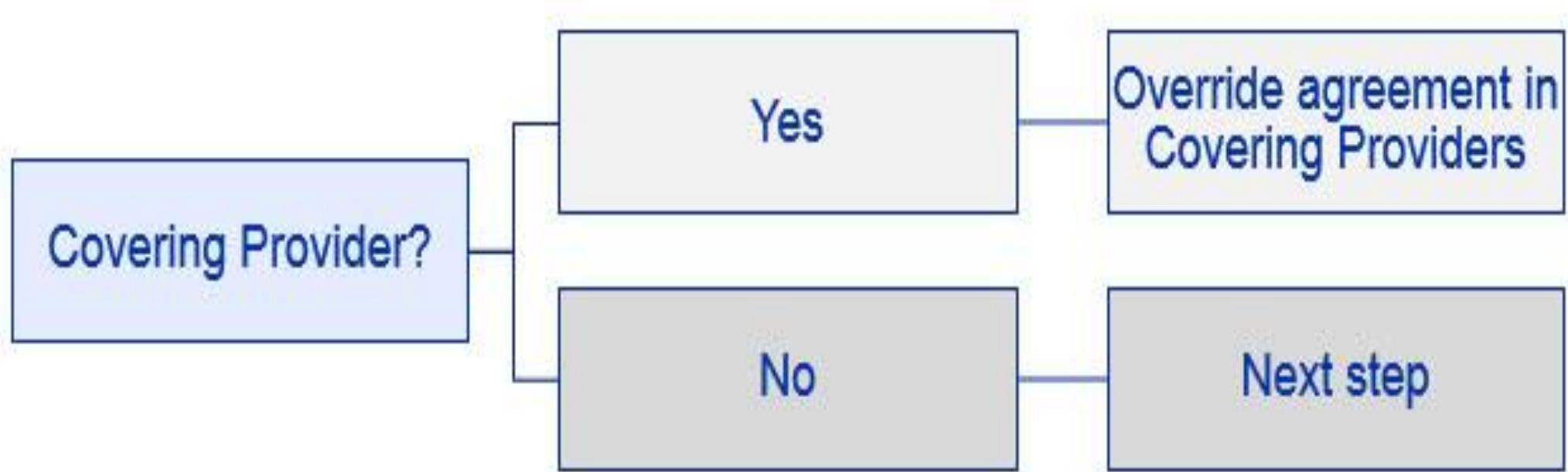
Network-Provider Structure



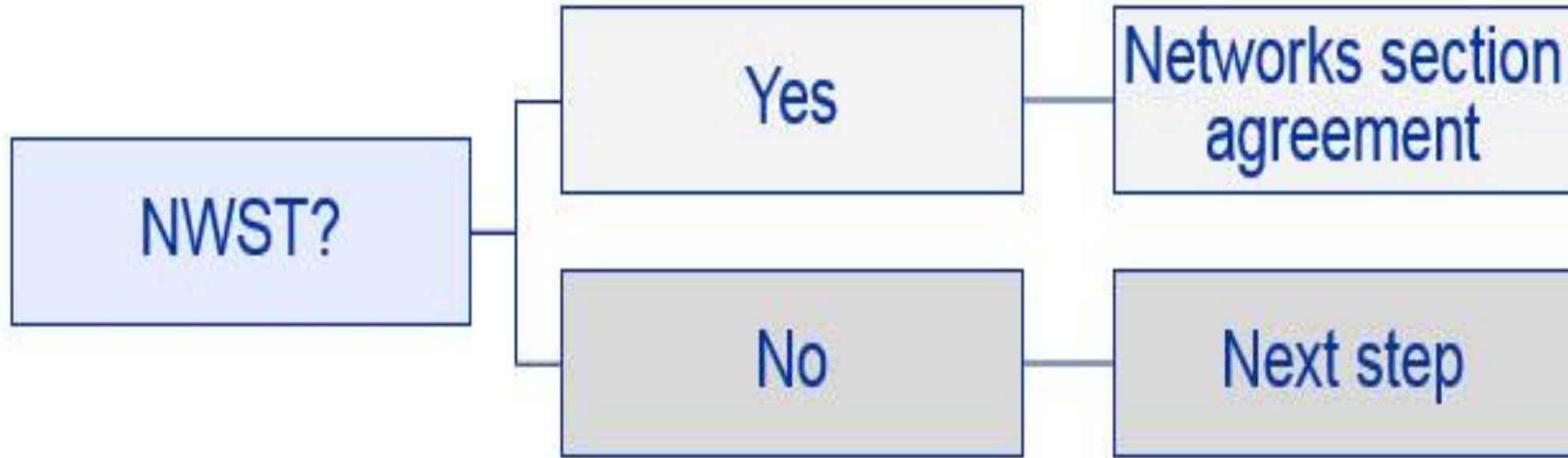
Network-Provider Process Flow: PCP



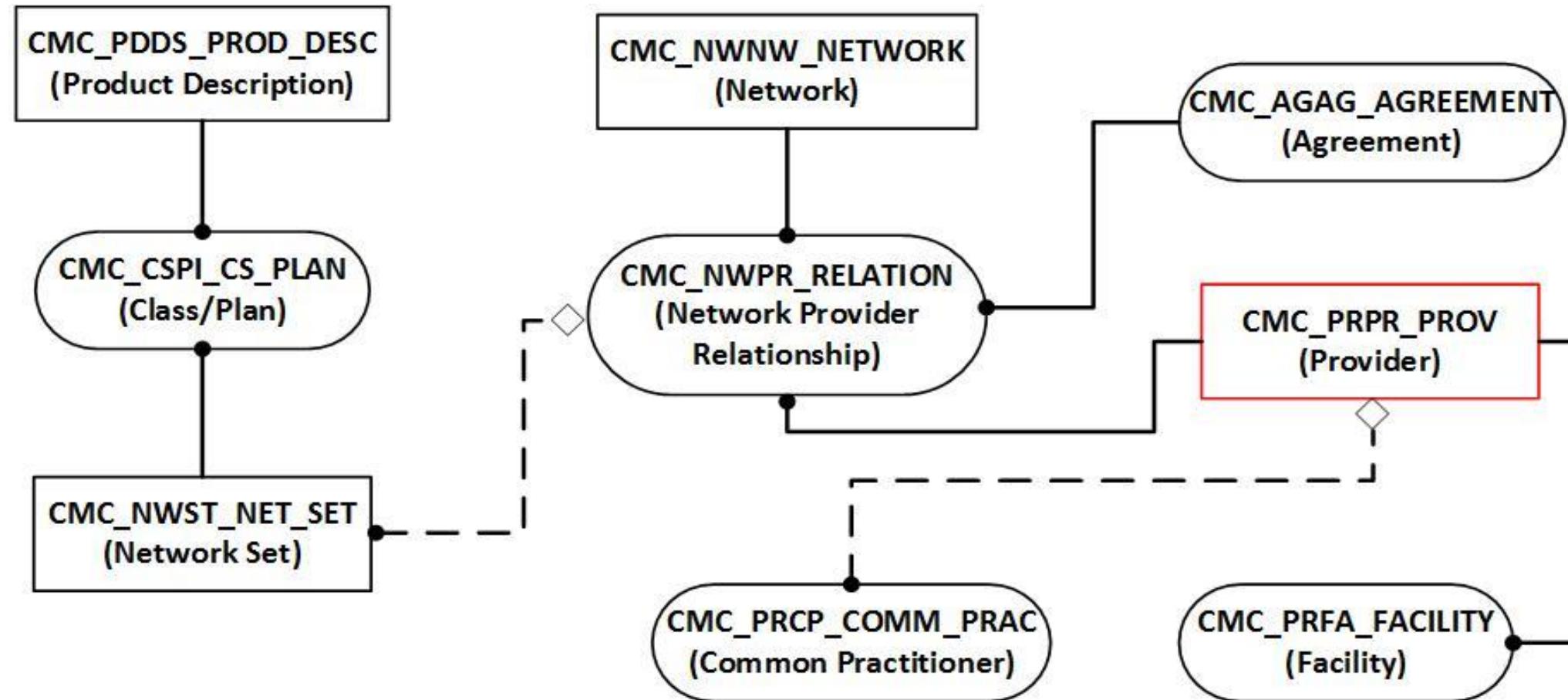
Network-Provider Process Flow: Covering Provider



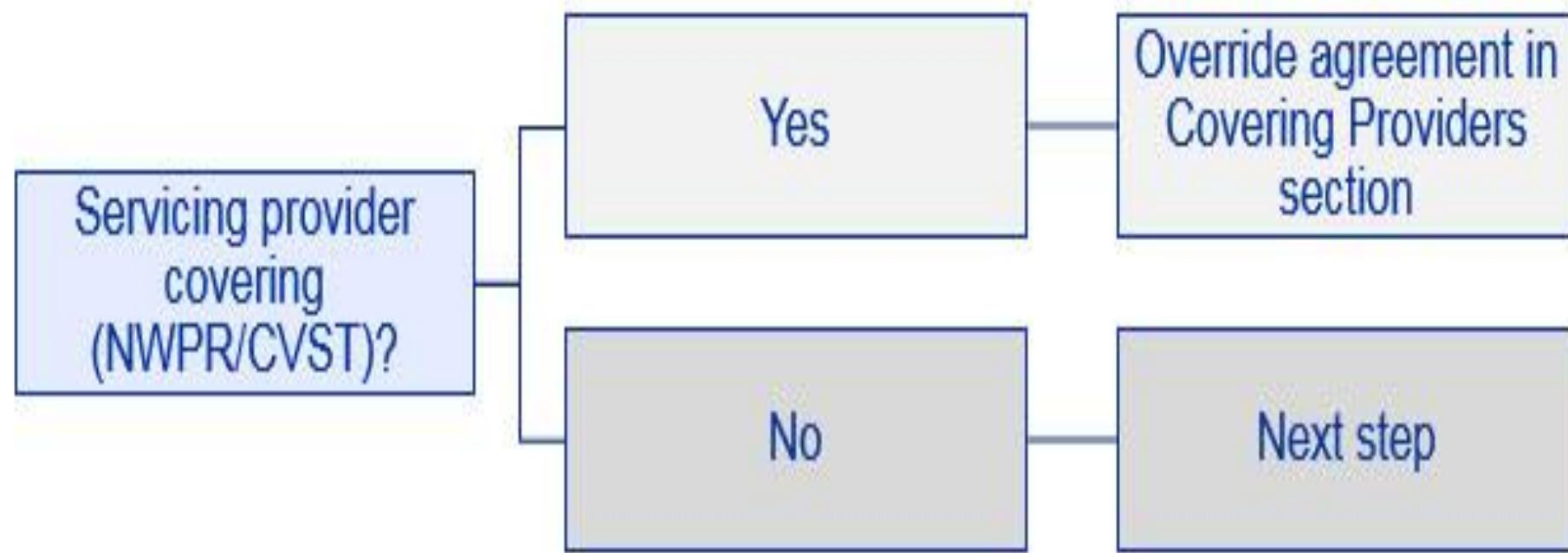
Network-Provider Process Flow: NWST



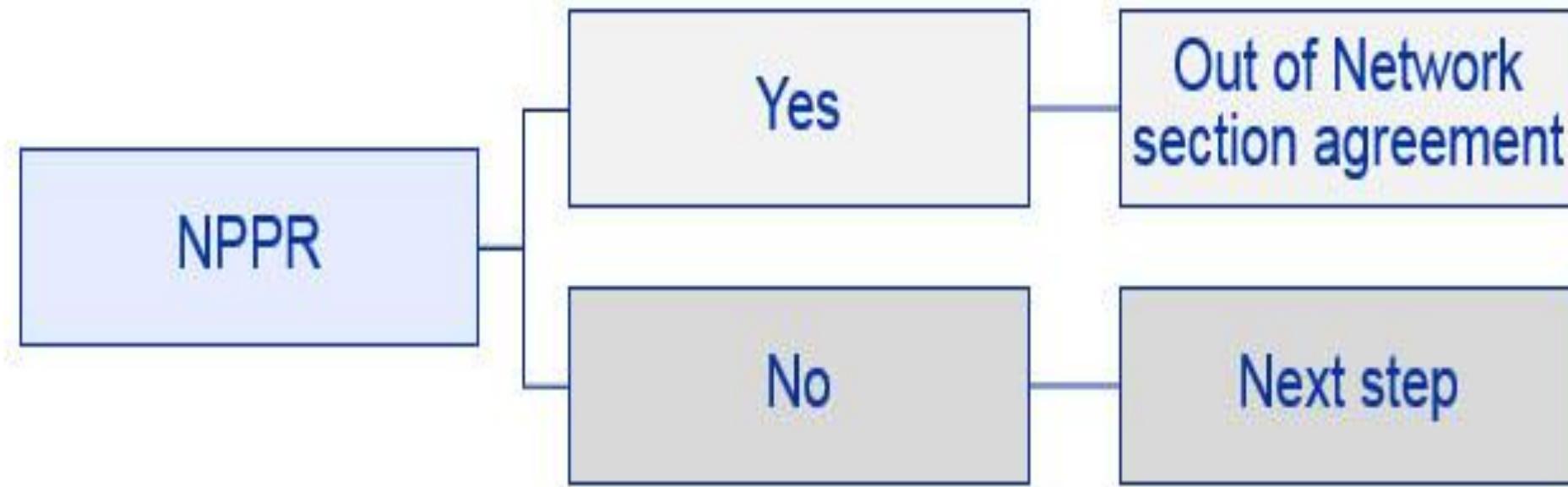
Network-Provider Process Flow



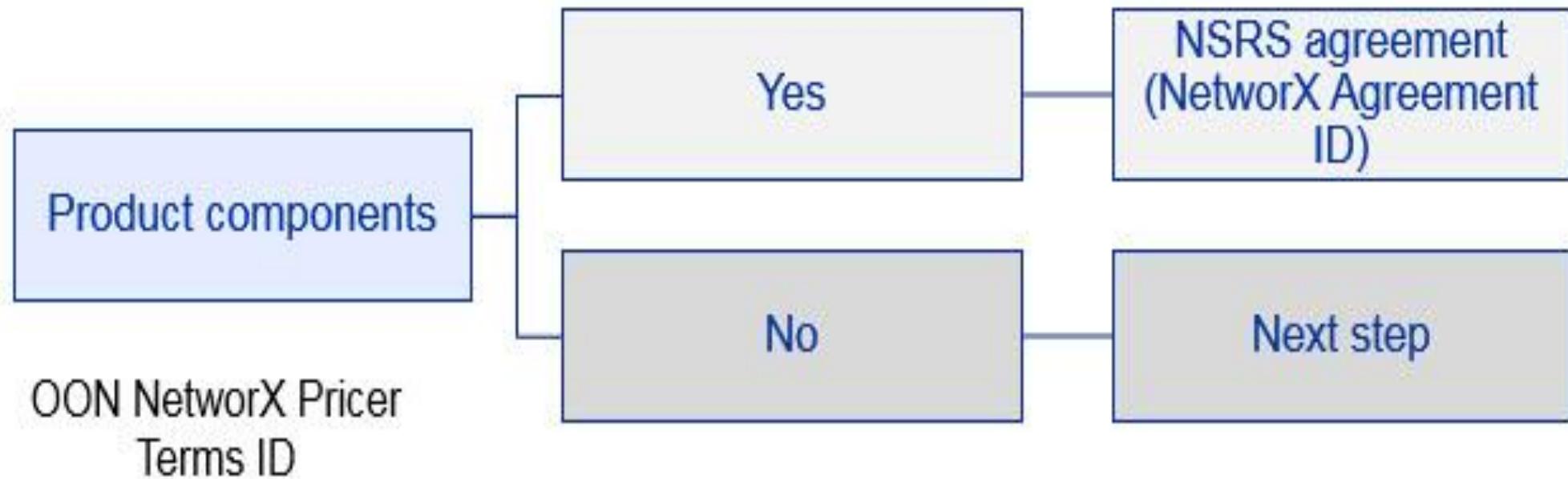
Network-Provider Process Flow: Servicing Provider



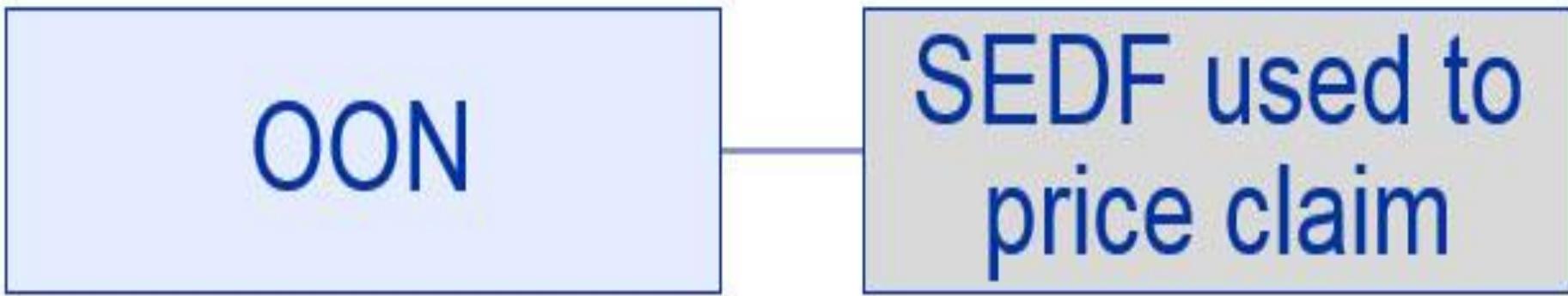
Network-Provider Process Flow: NPPR



Network-Provider Process Flow: Product Components



Network-Provider Process Flow: OON



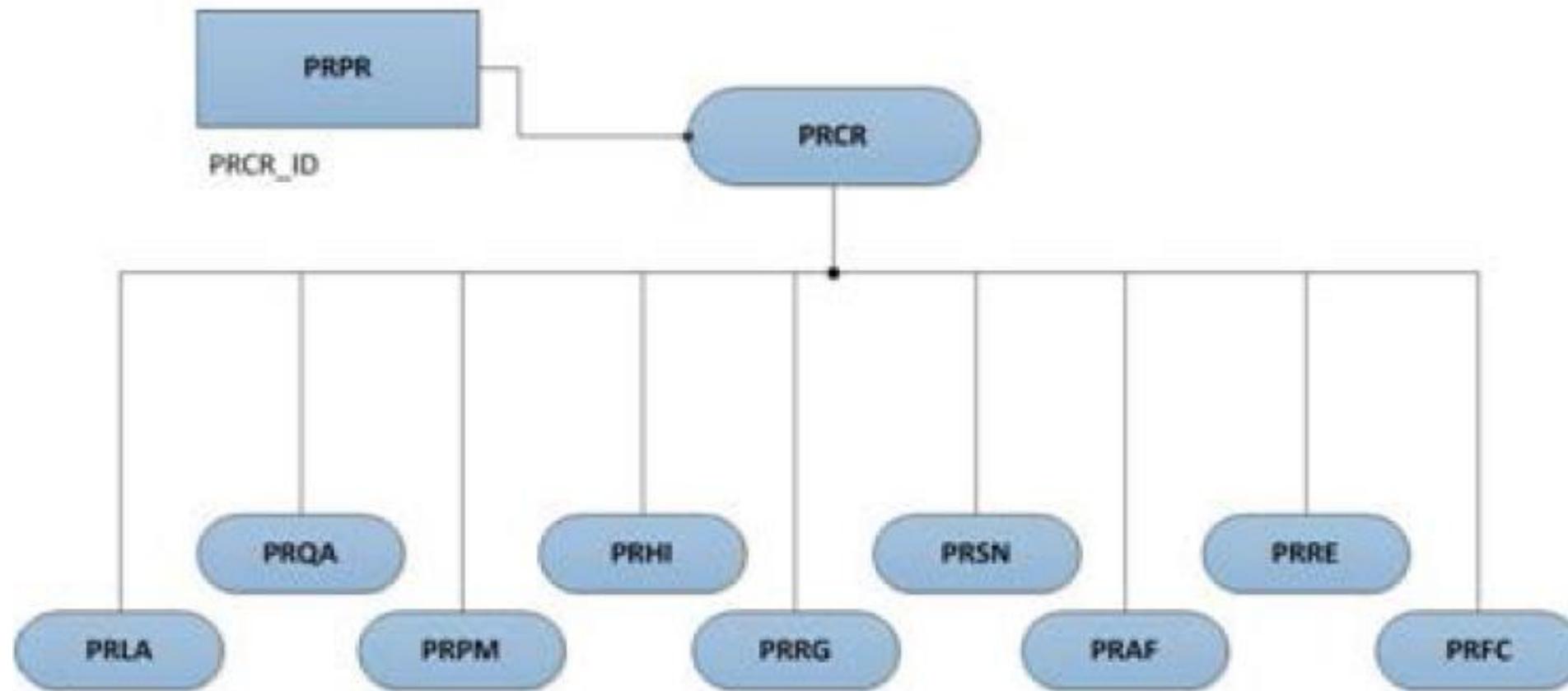
Provider Date Sensitivity

Provider date sensitivity as it relates to non-provider applications and functionality in Facets:

Date Sensitive Segments / Applications	Provider	Provider Address	Provider Payee	Tax Info
Accounting	Both Active and Terminated (Provider to be active as of DOS)	Active Address	Effective Payee as of DOS	Effective TIN as of Paid Date
Capitation	Active Providers	Active Address	Effective Payee as of Earn Date	Effective TIN as of Paid Date
Claims	Active Providers	Active Address	Effective Payee as of DOS	Effective TIN as of Paid Date
Customer Service/Appeals	Both Active and Terminated	Active Address (Mailing)	NA	NA
Channeling	Active Providers	Active Address	NA	NA
PCP Selection	Active Providers	Active Address	NA	NA
Search	Both Active and Terminated	Both Active and Terminated	NA	NA
UM	Active Providers	Active Address	NA	NA

Provider Credentialing

- Facets houses optional credentialing tables. Each table holds specific information about the provider





Questions?



Thank you

Appendix

Provider Table Structure

CMC_PRPR_PROV	Meaning
PRPR_ID	Provider Identifier
PRPR_ENTITY	Provider Entity
PRCR_ID	Credentialing ID
PRPR_PAY_CL_METH	Provider Claim Payment Combined Check Indicator
PRPR_NAME	Provider Name (* Important for provider group, IPA, Facility)
PRPR_NPI	National Provider Index
PRCP_ID	Common Practitioner ID
PRAD_ID	Provider Address ID
PRAD_TYPE_CHECK	Provider Remittance Address Type
PRAD_TYPE_PRIM	Provider Primary Address Type
MCTN_ID	Provider Tax Identification Number for search and reporting purposes
PRPR_STS	Provider Status (Functionality only tied to the ITS related values)
PRPR_PREAUTH_IND	Provider Pre-authorization Indicator
PRPR_PAY_HOLD_DT	Provider Payment Hold Date
PRPR_CL_EFT_IND	Provider Claims EFT Check Box
PRPR_CAP_EFT_IND	Provider Capitation EFT Check Box
PRPR_TERM_DT	Provider Termination Date
PRPR_PR_RED_CD	Provider Overpayment Recovery Indicator Value

CMC_PRPR_PROV
 PRPR_ID
PRPR_ENTITY*
PRCR_ID*
TPCT_MCTR_TCAT
PRPR_PAY_CL_METH*
PRPR_MCTR_TYPE
PRPR_MCTR_PRTY
PRCF_MCTR_SPEC
PRPR_NAME*
PRPR_NPI
PRCP_ID*
PRAD_ID*
PRAD_TYPE_CHECK*
PRAD_TYPE_PRIM*
MCTN_ID
PRPR_STS
PRPR_PREAUTH_IND
PRPR_PAY_HOLD_DT
PRPR_NAME_XLOW*
PRPR_MCTR_VAL1

Provider Table Structure – Contd..

CMC_MCTN_TAX_NAME Maintains Tax Name data, which includes a Tax address	
MCTN_ID	TAX ID
MCTN_TYPE	Tax Type (E-Employee Identification Number, S- SSN)
MCTN_NAME	Corporation Tax Name
MCTN_STATUS	Tax Reporting Status (N-Non-Reportable, R-Reportable)

CMC_MCTN_TAX_NAME	
	MCTN_ID
	MCTN_TYPE
	MCTN_NAME
	MCTN_LST_NAME
	MCTN_FIRST_NAME
	MCTN_STATUS
	MCTN_ADDR1
	MCTN_CITY
	MCTN_STATE
	MCTN_ZIP
	MCTN_COUNTY
	MCTN_PHONE
	MCTN_FAX
	MCTN_EMAIL

CMC_MCTI_TAX_INFO	
	Contains the date the relationship between the Tax ID owner and the Tax ID began or ended
MCTI_ENTY_ID	Entity ID
MCTI_TYPE	C-Commission Entity , P – Provider Entity
MCTI_EFF_DT	Tax Effective start date
MCTI_TERM_DT	Tax Term date
MCTN_ID	TAX ID

CMC_MCTI_TAX_INFO	
	MCTI_ENTY_ID
	MCTI_TYPE
	MCTI_EFF_DT
	MCTI_TERM_DT
	MCTI_MCTR_TRSN
	MCTN_ID
	MCTN_TYPE

Provider Address Table – Contd..

This stores address information for each provider by Address type : Primary, Mailing, etc., up to a maximum of 60 addresses per provider

Column Name	Details
PRAD_ID	Provider Address ID -> PRPR_ID By default
PRAD_TYPE	User defined code up to THREE characters
PRAD_EFF_DT	Effective date for this address type
PRAD_TERM_DT	Term Date
PRAD_ADDR1	Address1
PRAD_CITY	City
PRAD_STATE	State
PRAD_ZIP	ZIP
PRAD_HD_IND	Handicap Indicator
PRAD_PRACTICE_IND	It allows for accessibility in the channeling process. Mail text box automatically populates with the address
PRAD_TYPE_MAIL	With the exception of Checks, remittances and EOB's, all providers receive all other correspondence to this MAIL TYPE
PRAD_DIRECTORY_IND	Practice Address to Default directory (I – include or E-Exclude)

CMC_PRAD_ADDRESS
PRAD_ID
PRAD_TYPE
PRAD_EFF_DT
PRAD_TERM_DT
PRAD_ADDR1*
PRAD_CITY*
PRAD_STATE*
PRAD_ZIP*
PRAD_COUNTY
PRAD_CTRY_CD
PRAD_PHONE
PRAD_FAX
PRAD_EMAIL
PRAD_PRACTICE_IND*
PRAD_TYPE_MAIL*

Provider Entity Relationship

CMC_PRER_RELATION

- This table stores relationship information between provider entities, groups, IPAs or Sponsors.
- The Provider Group and IPA PRER relationships are read during the processing applications, except capitation

Column Name	Details
PRPR_ID	Provider ID
PRER_PRPR_ENTITY	Provider Entity Relationship
PRER_EFF_DT	Provider Entity Relationship Effective Date
PRER_TERM_DT	Provider Entity Relationship Termination Date
PRER_PRPR_ID	Provider Entity Relationship Identifier

Provider Credentialing

Optional Credentialing Tables	Definition
CMC_PRCR_CREDEN	This table provides provider global credentialing information
CMC_PRLA_LANG	This table provides Common Practitioner Language Availability
CMC_PRAF_AFFIL	It provides provider Relationship with Facility Information
CMC_PRQA_QA	It provides provider quality assurance information
CMC_PRPM_RELATION	It provides provider Malpractice information
CMC_PRRG_REG	It provides Provider Registration Indicative information
CMC_PRHI_HIST	It provides Provider specific Professional History information

Provider Credentialing – Contd..

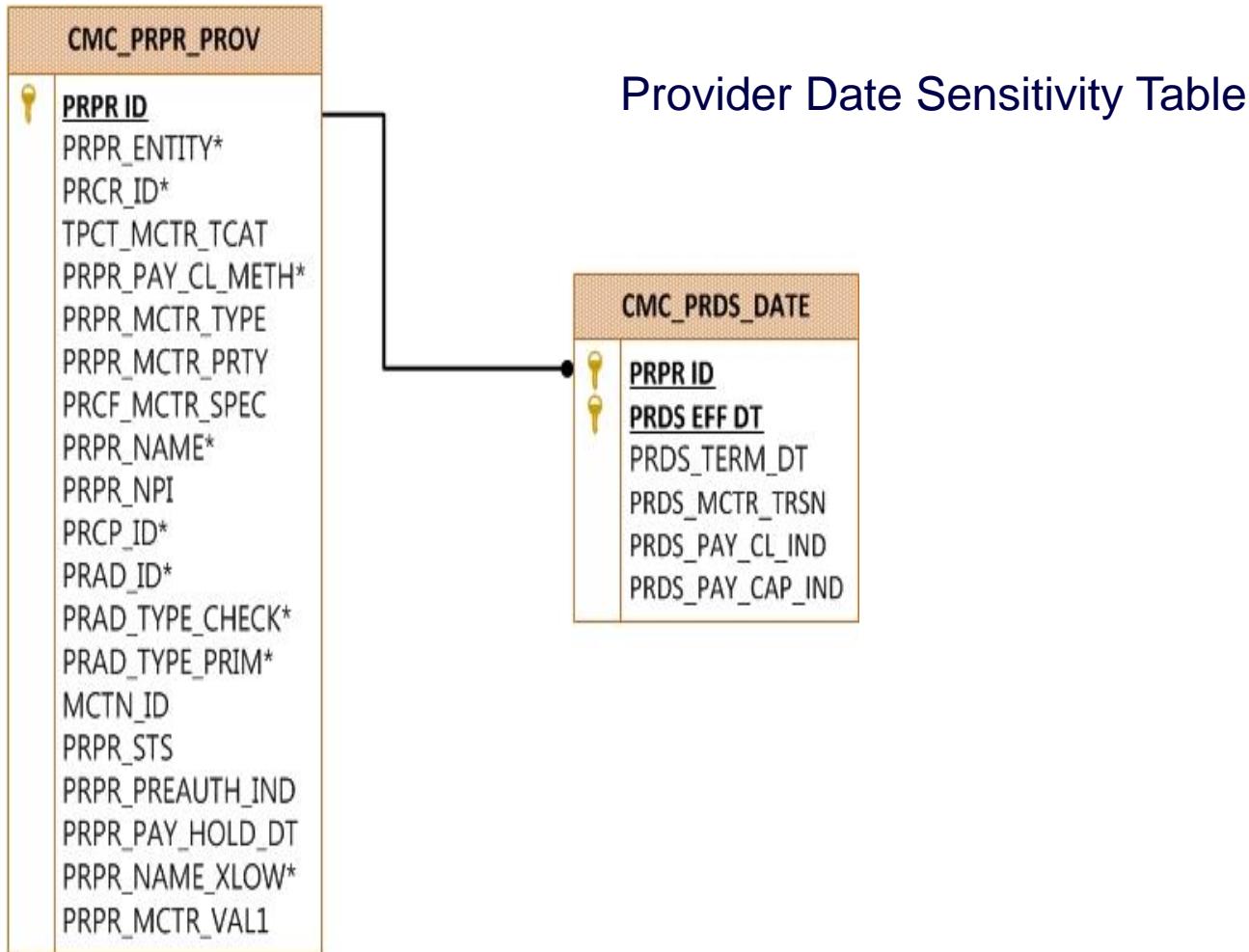
Optional Credentialing Tables	Definition
CMC_PRRE_RELATION	Provides Managed Care Related Entity Relationship Information
CMC_PRSN_SANCTION	Provides Provider Level Sanction Information
CMC_PRFC_CERT	Provides Common Practitioner Board Status Information

Provider Agreement

The Provider Agreement table stores the base information for a provider agreement and is where the Agreement ID is created.

CMC_AGAG AGREEMENT	Stores the information for a provider agreement and is where the Agreement ID is created
AGAG_ID	Agreement ID
AGAG_EFF_DT	Agreement Effective date
AGAG_TERM_DT	Agreement termination date
AGAG_CAT	Provider Agreement Category (D, M, V)
AGAG_IP_PRICE_IND	NXP identifier for Inpatient facility agreements
AGAG_OP_PRICE_IND	NXP identifier for Outpatient facility agreements
AGAG_NWX_PROF_IND	NXP for professional provider like an MD
AGSE_PFX	AG Service Definition ties to an AG Product
PFPPF_ID	Profile ID Links to Unique payment – like PFFS

Tables



Tables

Provider Network Relationship

NWPR
**(Network Provider
Relationship)**

CMC_NWPR_RELATION	
	PRPR_ID
	NWNW_ID
	NWPR_PFX
	NWPR_PCP_IND
	NWPR_EFF_DT

NWPE
**(Network PCP Cap
Relationship)**

CMC_NWPE_RELATION	
	PRPR_ID
	NWNW_ID
	NWPE_PFX
	NWPE_CR_PR_ID
	NWPE_EFF_DT

NWCR
**(Network Capitation
Relationship)**

CMC_NWCR_RELATION	
	NWNW_ID
	NWCR_PFX
	NWCR_CR_PR_ID
	NWCR_EFF_DT



Facets – Product

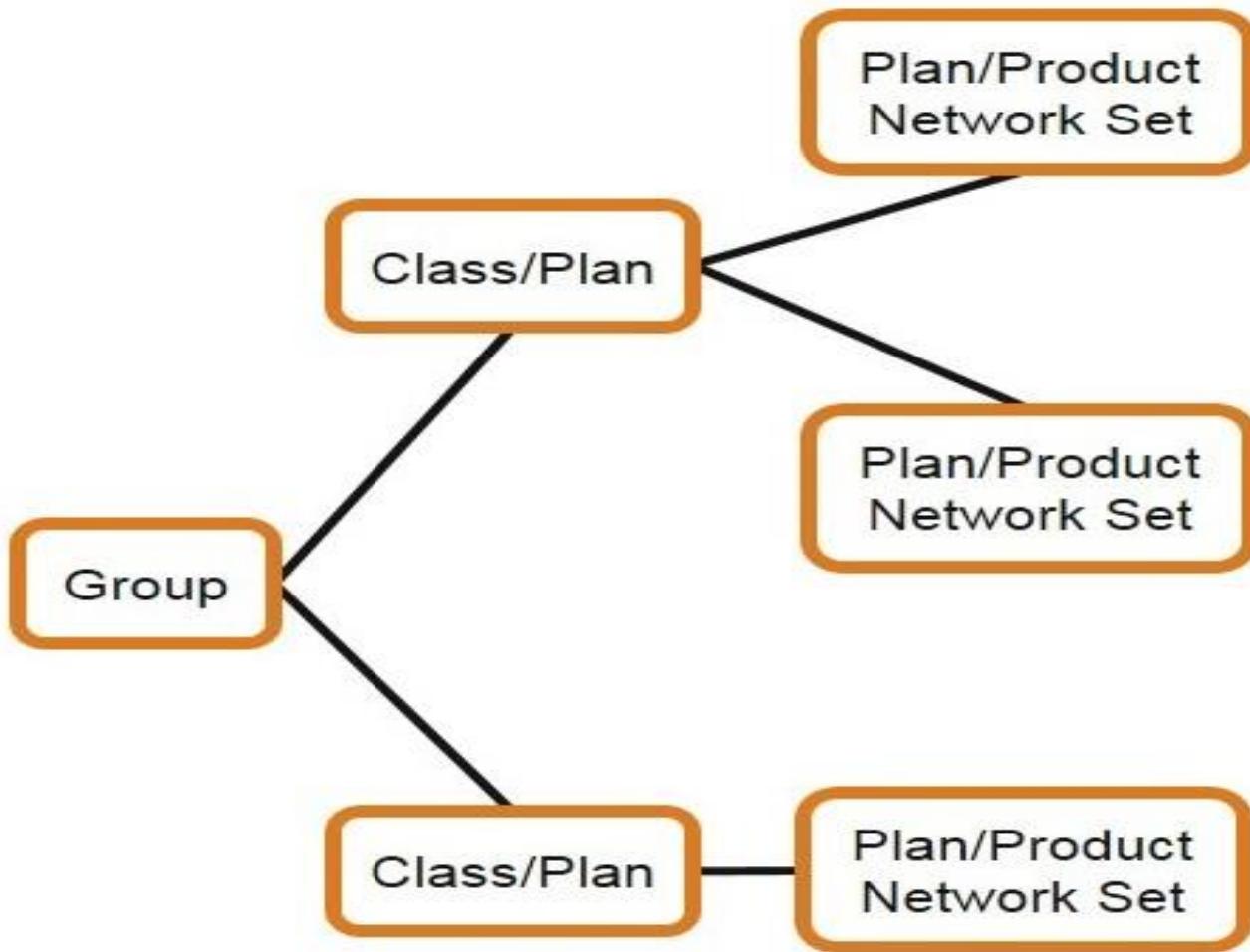
Plan, Product, and Administrative Component

Learning Services

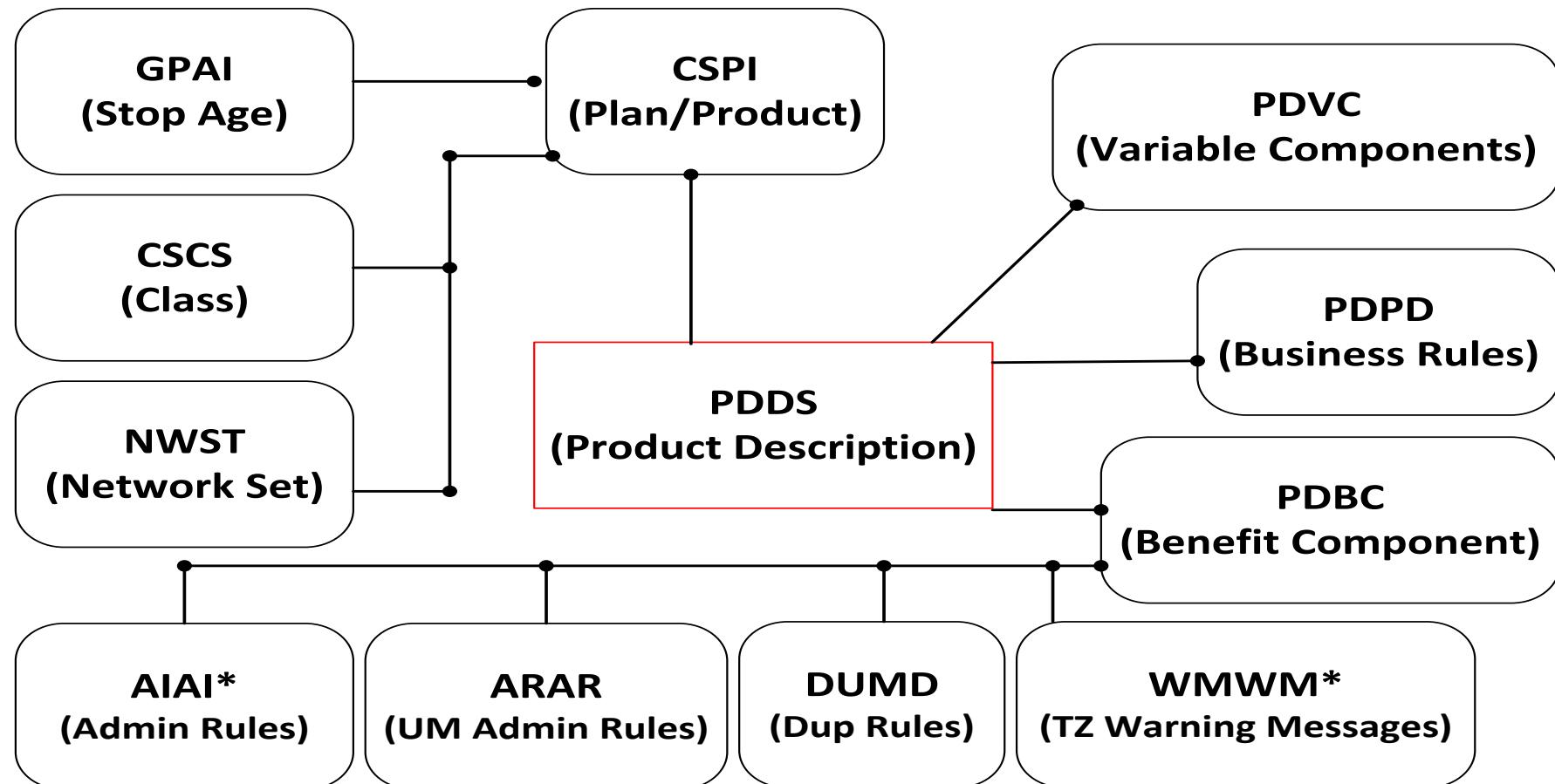
Agenda

- Group, Class and Plan Construction
- Product Setup
- Components
- Variable Components

Group, Class, and Plan Construction

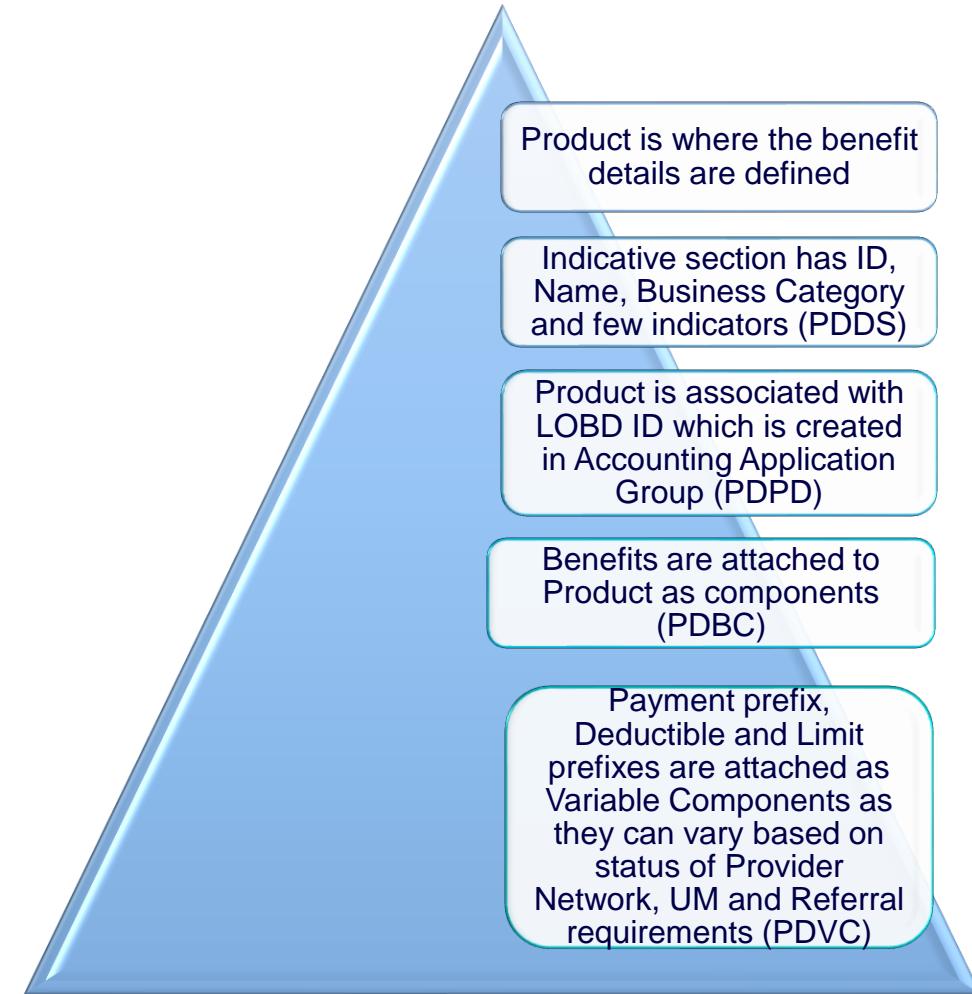
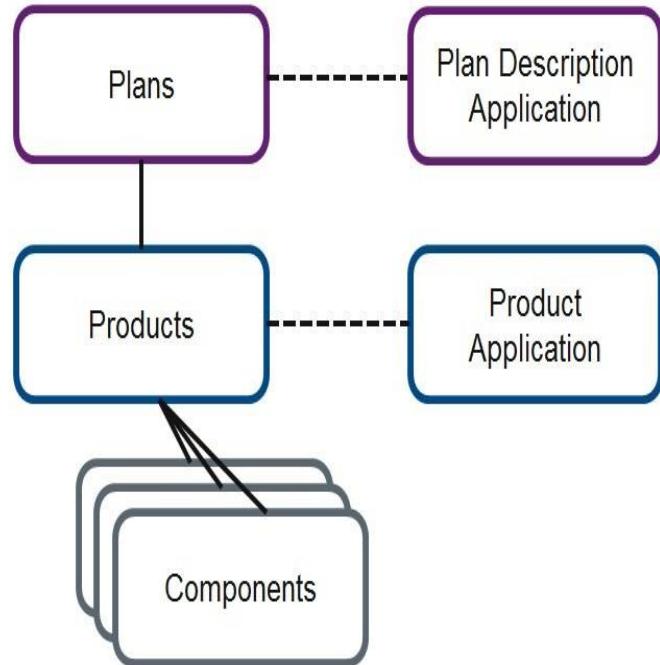


Plan Data Model

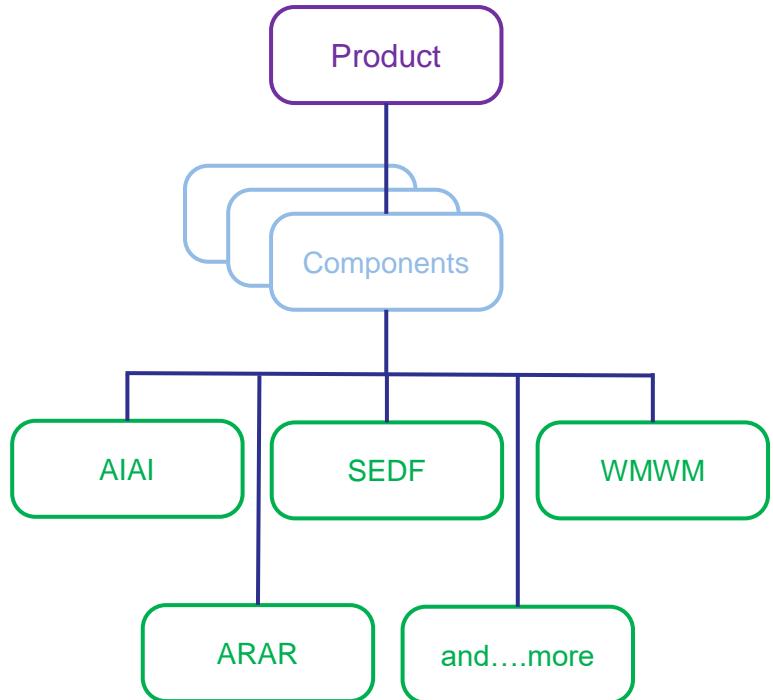


*Required

Plans and Products



Product Components



Some components like AIAI, SEDF, WMWM etc. are required components

Facets displays warning messages when required components are not added

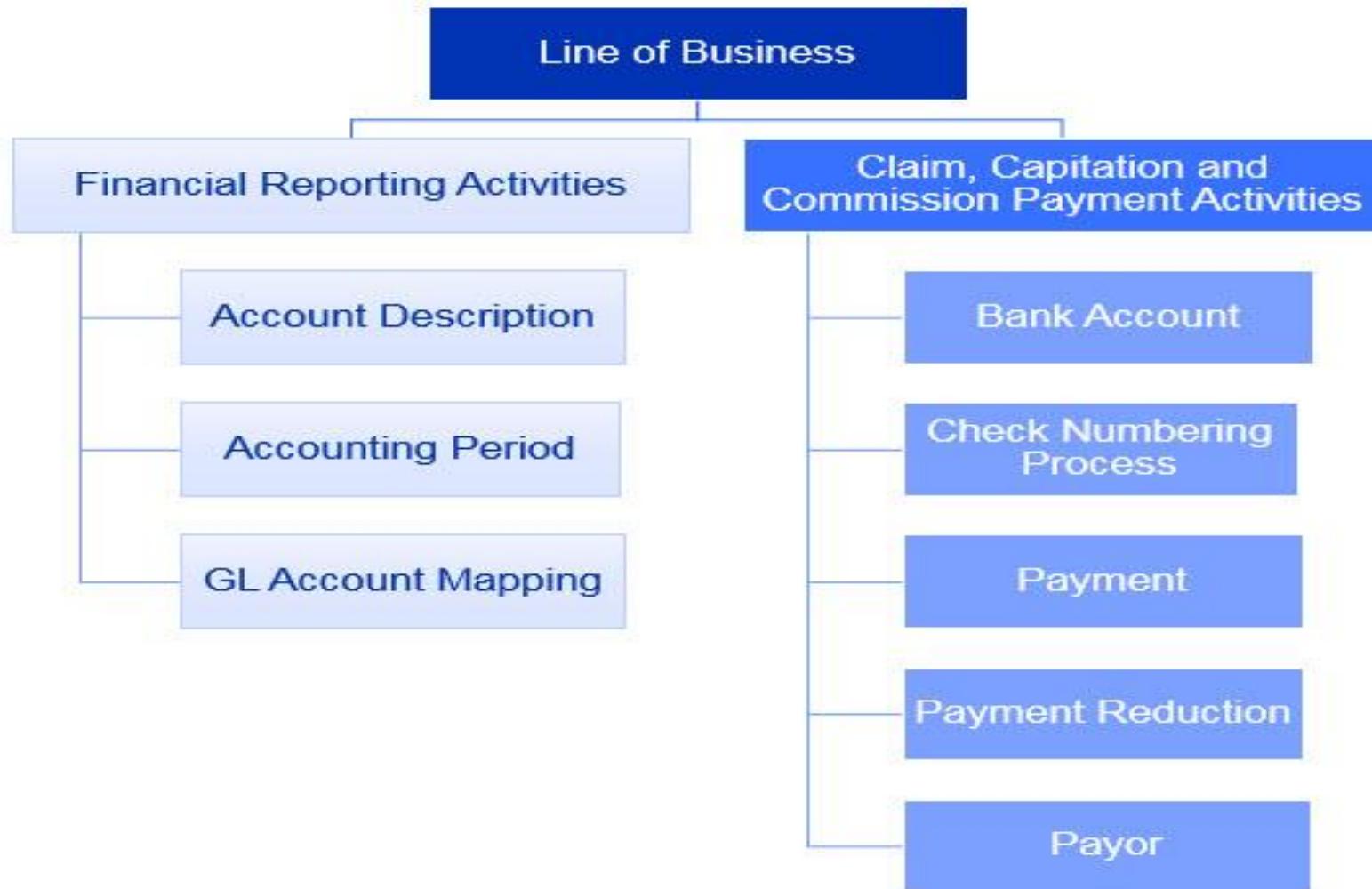
Required components may vary depending on Indicators on Indicative Page

- Example: ARAR is required when Referrals & Pre-Auths are checked and is used to setup rules for UM Processing

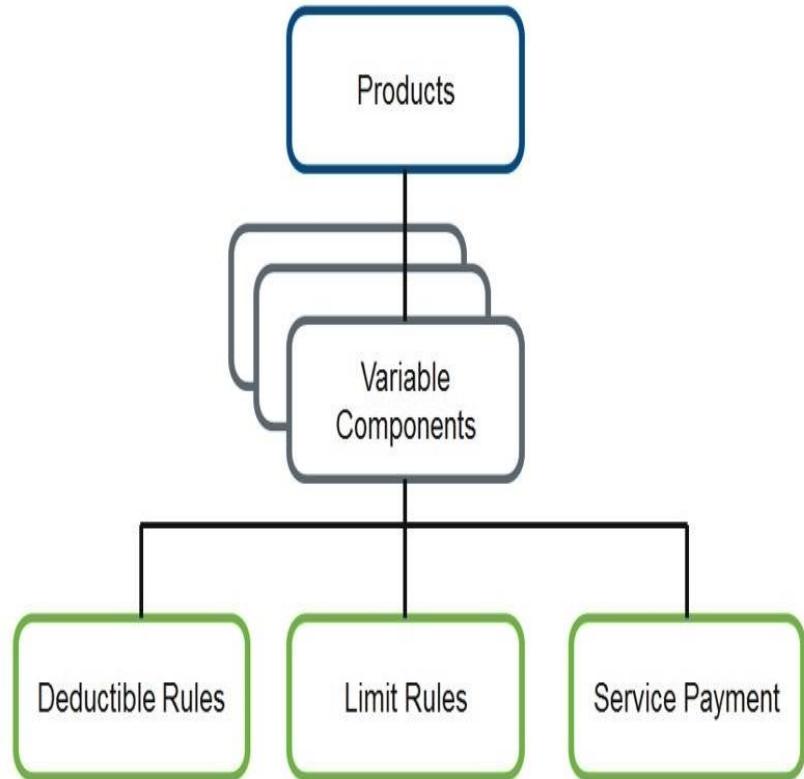
Some are optional components which can be added depending on functionality

- Example: ZCIA is attached if out-of-area processing is required for product

Line of Business



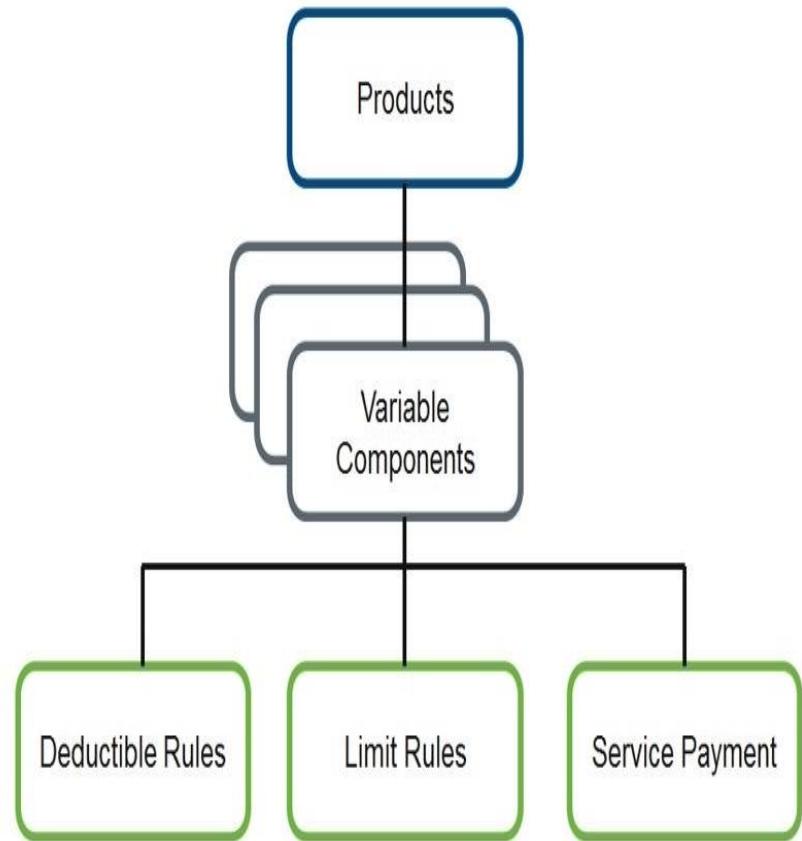
Product Variable Components



Variable Components page identifies the Service Payment, Deductible Rules and Limit Rules prefixes during processing medical claims or UM reviews

Prefixes change based on who performed the services, the tier of the provider, whether the service was performed in or out of network, and if utilization management requirements were satisfied - and hence Variable

Product Variable Components – Contd...



Can establish up to 36 date-sensitive combinations for each Type, and each Type can have one or more Tiers

Variable components should be defined for at least Tier 1 of Standard (in-area, non-accident, non-emergency)

Product Variable Components – Contd..

Tier	Type	Provider	Pre-Auth	Referral	SEPY (Copay, Colns)	Ded	Limit	LOBD
1	Standard	PCP	Not-Required	Not-Required	SE01	DE01	LT01	Primary
1	Standard	PCP	Not-Required	Obtained	SE01	DE01	LT01	Primary
1	Standard	PCP	Not-Required	Violated	SE03	DE02	LT02	Primary
1	Standard	PCP	Obtained	Not-Required	SE01	DE01	LT01	Primary
1	Standard	PCP	Obtained	Obtained	SE01	DE01	LT01	Primary
1	Standard	PCP	Obtained	Violated	SE03	DE02	LT02	Primary
1	Standard	PCP	Violated	Not-Required	SE03	DE02	LT02	Primary
1	Standard	PCP	Violated	Obtained	SE03	DE02	LT02	Primary
1	Standard	PCP	Violated	Violated	SE03	DE02	LT02	Primary
1	Standard	INN	Not-Required	Not-Required	SE01	DE01	LT01	Primary
1	Standard	INN	Not-Required	Obtained	SE01	DE01	LT01	Primary
1	Standard	INN	Not-Required	Violated	SE03	DE02	LT02	Primary
1	Standard	INN	Obtained	Not-Required	SE01	DE01	LT01	Primary
1	Standard	INN	Obtained	Obtained	SE01	DE01	LT01	Primary
1	Standard	INN	Obtained	Violated	SE03	DE02	LT02	Primary
1	Standard	INN	Violated	Not-Required	SE03	DE02	LT02	Primary
1	Standard	INN	Violated	Obtained	SE03	DE02	LT02	Primary
1	Standard	INN	Violated	Violated	SE03	DE02	LT02	Primary

Product Variable Components – Contd..

Tier	Type	Provider	Pre-Auth	Referral	SEPY (Copay, Colns)	Ded	Limit	LOBD
1	Standard	PAR	Not-Required	Not-Required	SE01	DE01	LT01	Primary
1	Standard	PAR	Not-Required	Obtained	SE01	DE01	LT01	Primary
1	Standard	PAR	Not-Required	Violated	SE03	DE02	LT02	Primary
1	Standard	PAR	Obtained	Not-Required	SE01	DE01	LT01	Primary
1	Standard	PAR	Obtained	Obtained	SE01	DE01	LT01	Primary
1	Standard	PAR	Obtained	Violated	SE03	DE02	LT02	Primary
1	Standard	PAR	Violated	Not-Required	SE03	DE02	LT02	Primary
1	Standard	PAR	Violated	Obtained	SE03	DE02	LT02	Primary
1	Standard	PAR	Violated	Violated	SE03	DE02	LT02	Primary
1	Standard	Non-PAR	Not-Required	Not-Required	SE02	DE02	LT01	Secondary
1	Standard	Non-PAR	Not-Required	Obtained	SE02	DE02	LT01	Secondary
1	Standard	Non-PAR	Not-Required	Violated	SE02	DE02	LT02	Secondary
1	Standard	Non-PAR	Obtained	Not-Required	SE02	DE02	LT01	Secondary
1	Standard	Non-PAR	Obtained	Obtained	SE02	DE02	LT01	Secondary
1	Standard	Non-PAR	Obtained	Violated	SE02	DE02	LT02	Secondary
1	Standard	Non-PAR	Violated	Not-Required	SE02	DE02	LT02	Secondary
1	Standard	Non-PAR	Violated	Obtained	SE02	DE02	LT02	Secondary
1	Standard	Non-PAR	Violated	Violated	SE02	DE02	LT02	Secondary

Administrative Info - AIAI

Defines primarily claims processing provisions

When you select the PCP Required check box, Facets displays a warning message at enrollment and during Claims Processing or Prospective UM processing that a PCP is required.

An Administrative Information component is required for every product

Payment Drag Provisions and Exception for Emergency Services can be setup.



Questions?



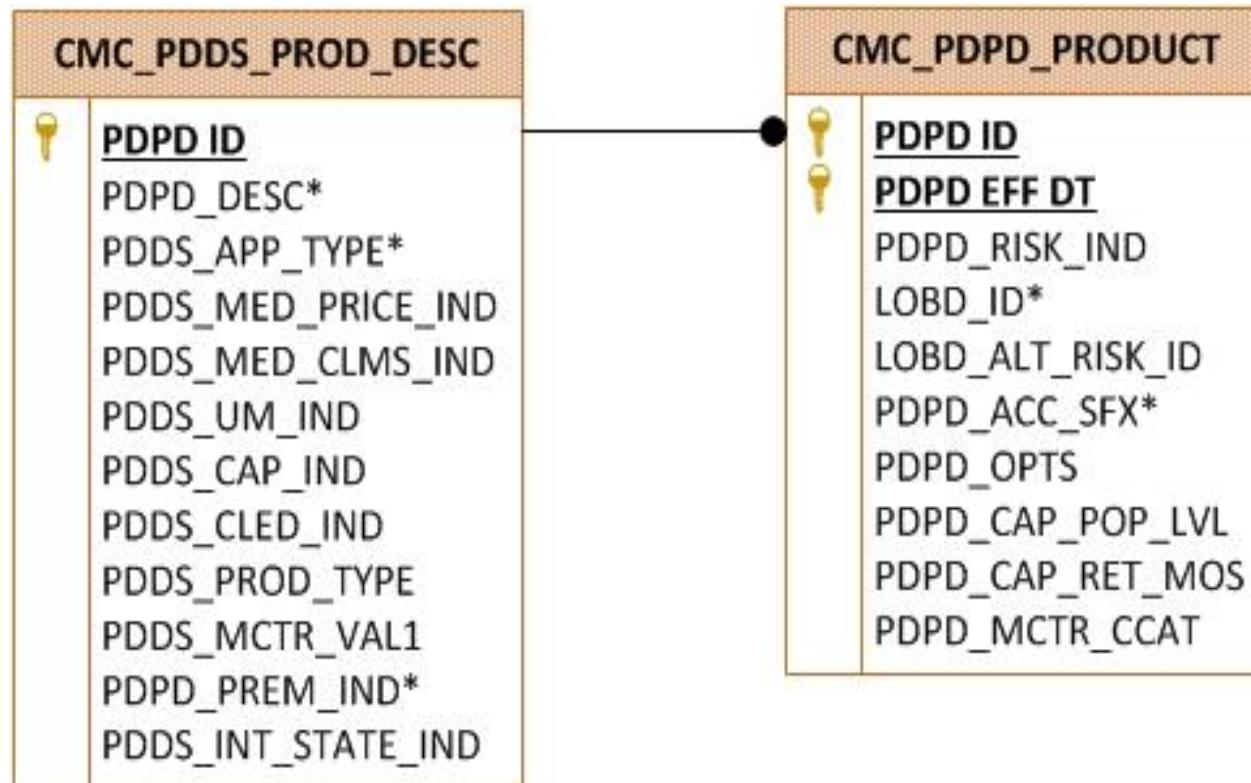
Thank you

Appendix

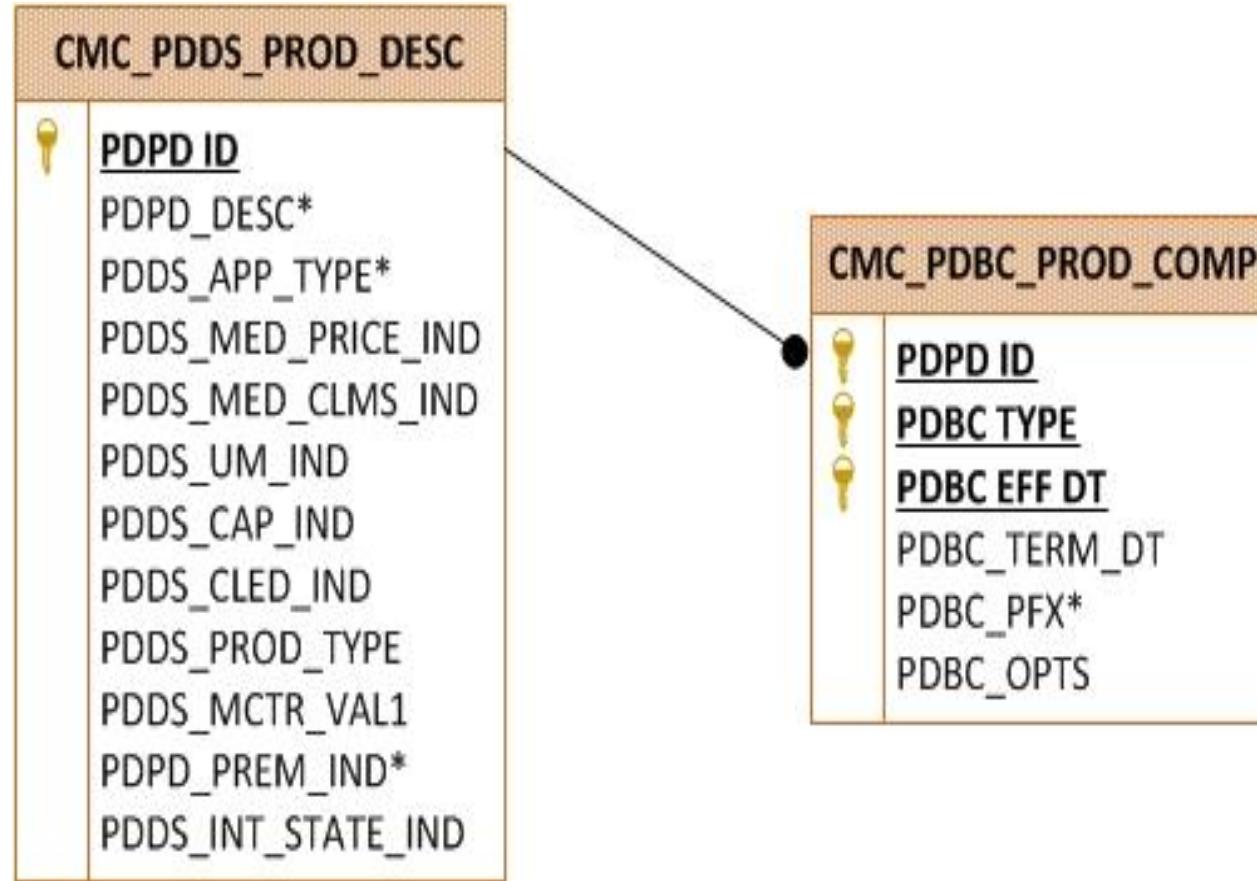
Product Description Table

CMC_PDDS_PROD_DESC	
	<u>PDID</u>
	PDID_DESC*
	PDDS_APP_TYPE*
	PDDS_MED_PRICE_IND
	PDDS_MED_CLMS_IND
	PDDS_UM_IND
	PDDS_CAP_IND
	PDDS_CLED_IND
	PDDS_PROD_TYPE
	PDDS_MCTR_VAL1
	PDID_PREM_IND*
	PDDS_INT_STATE_IND

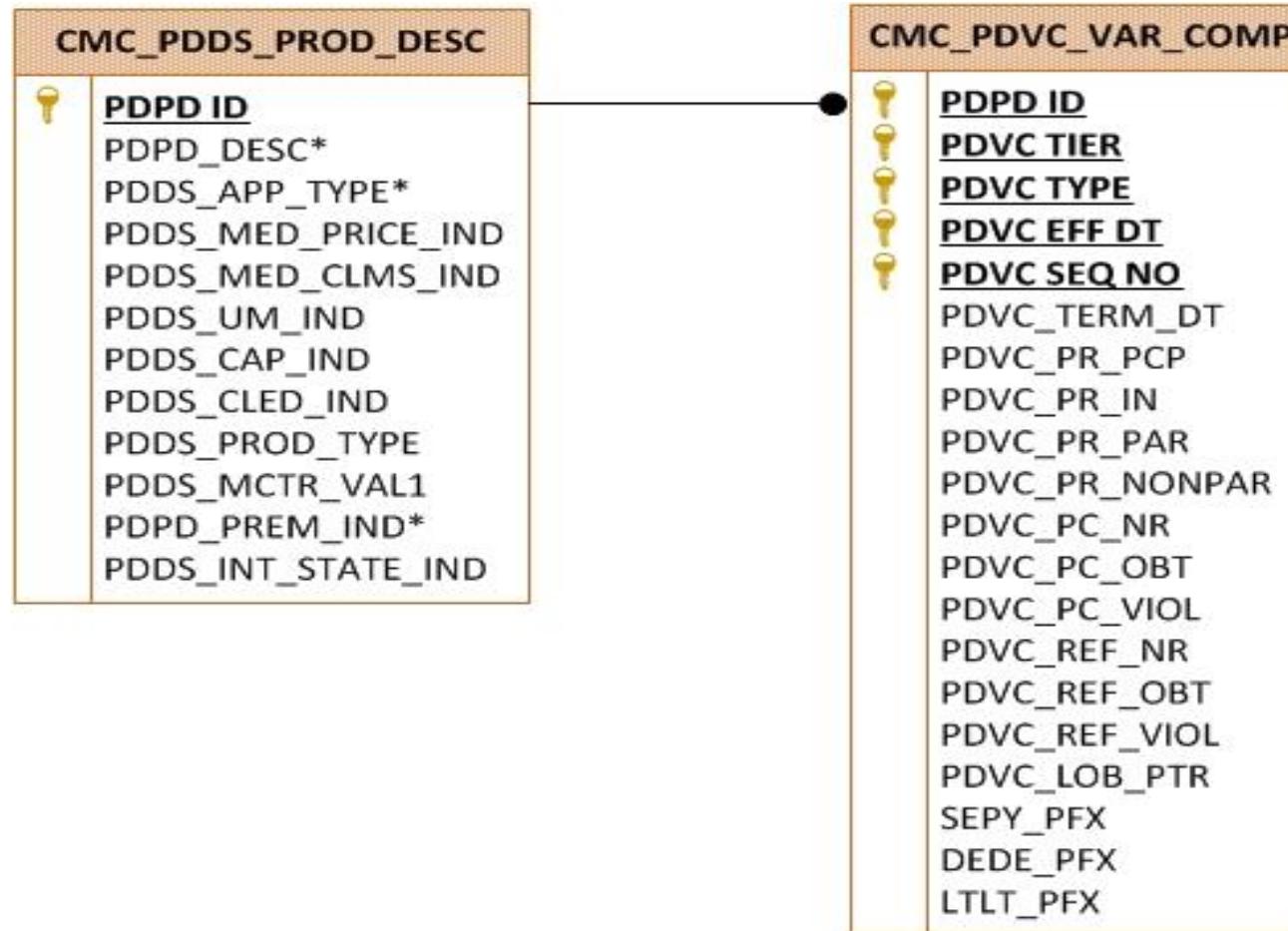
Product Table



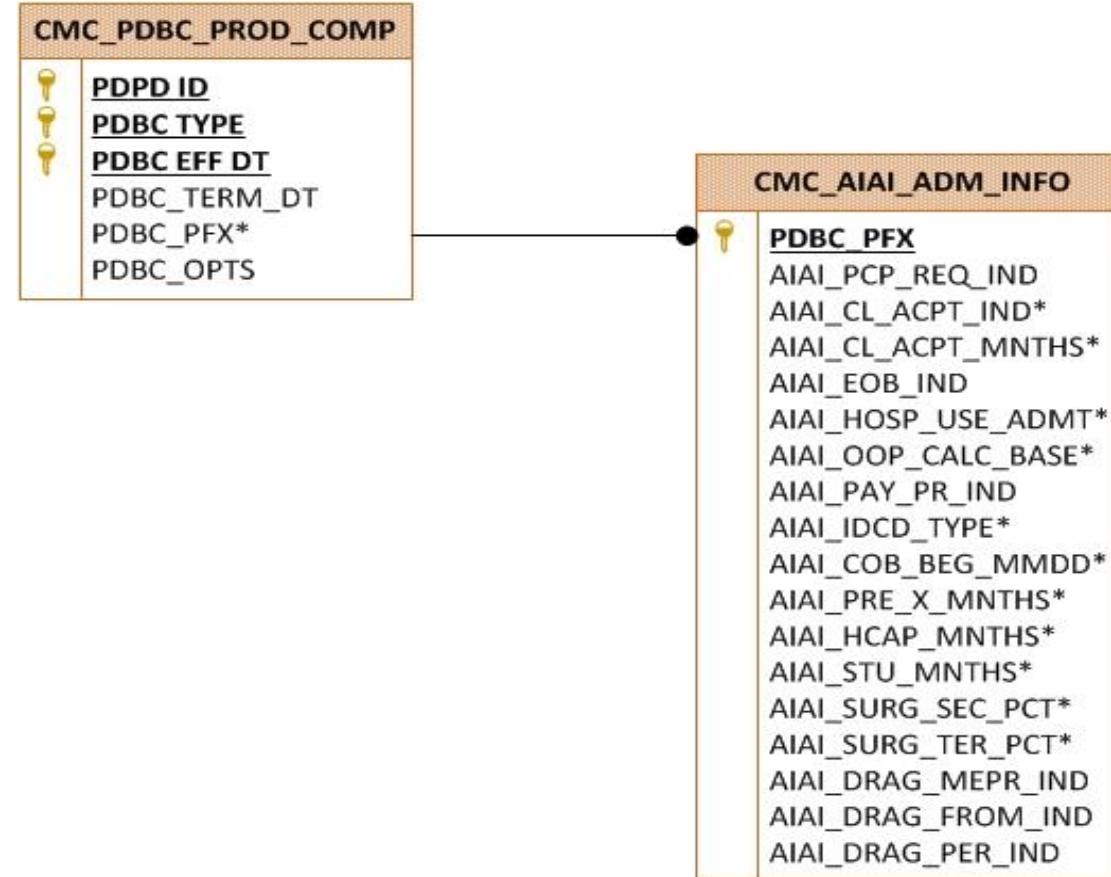
Benefit Components Table



Variable Components Tables



Administrative Information Table





Group/Subgroup , Class/Plan

Learning Services

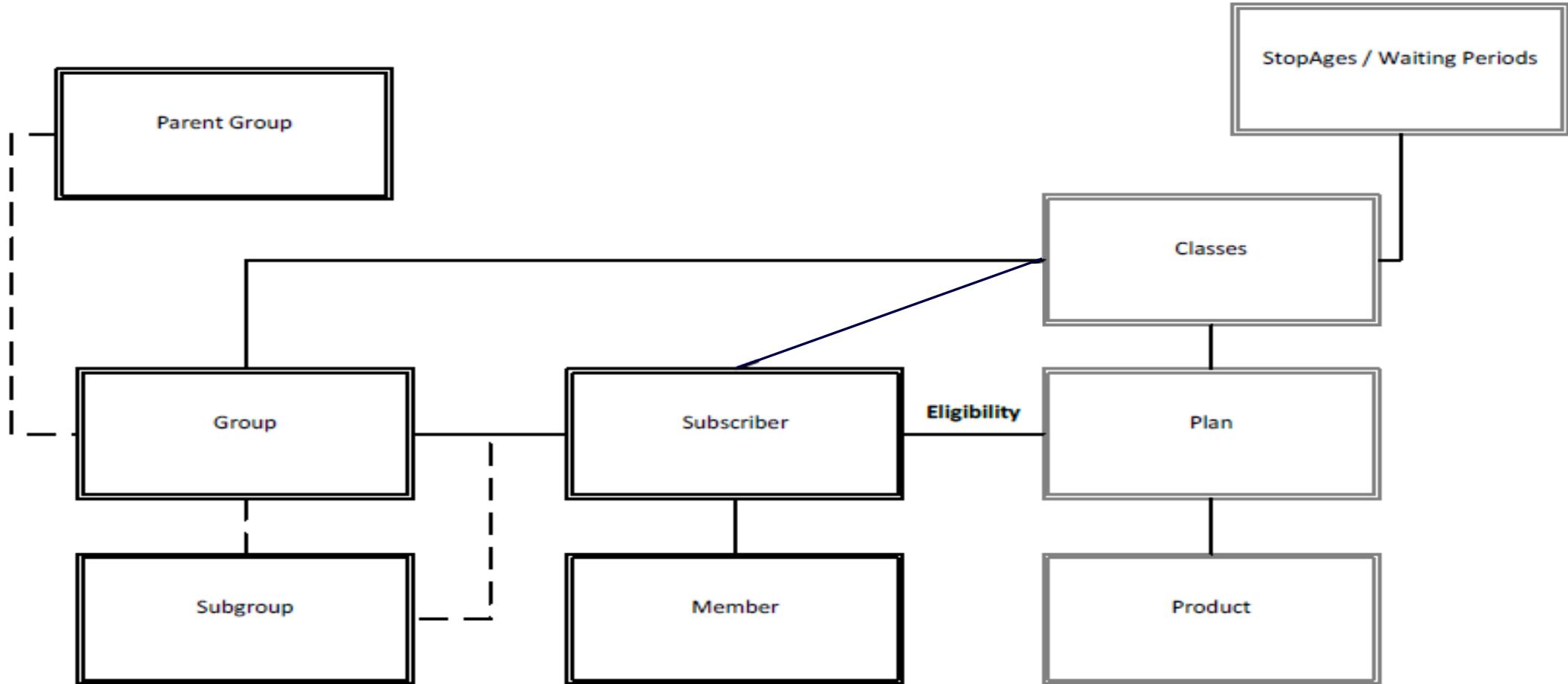
Agenda

- Group Structure
- Parent Group , Group and Subgroup
- Class/Plan Structure
- Stop Ages/Waiting Period
- Network Set

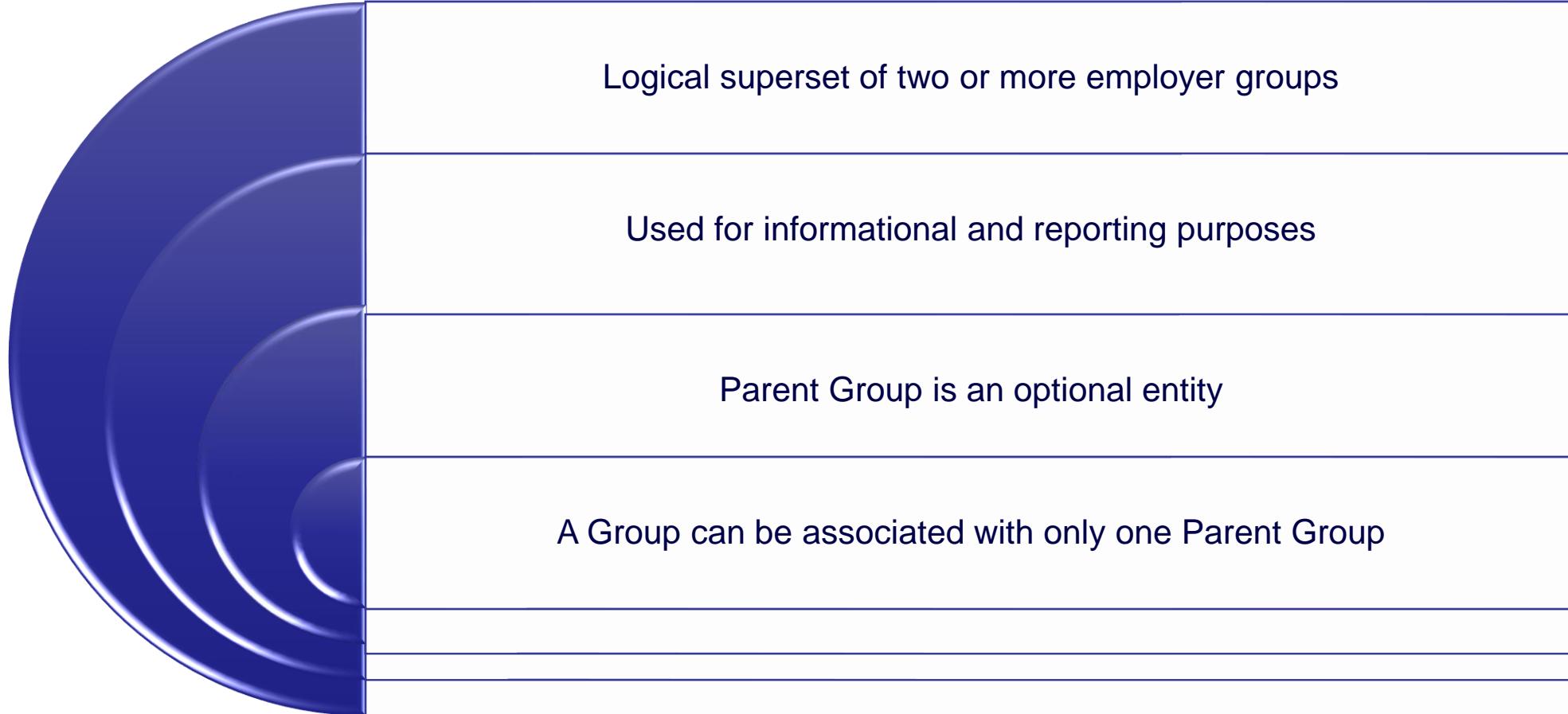


Parent Group, Group and SubGroup

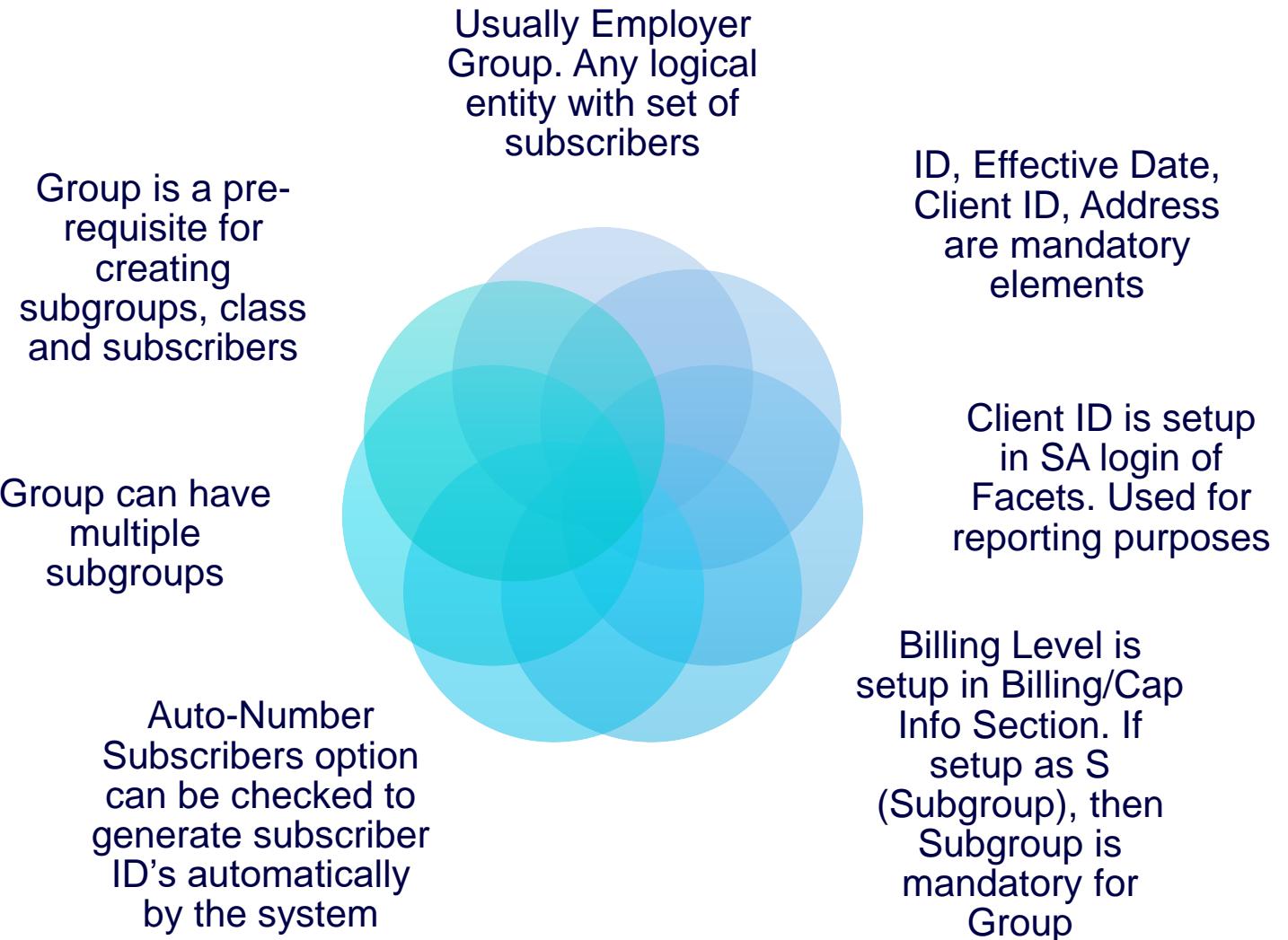
Group/Class/Plan/Product Structure



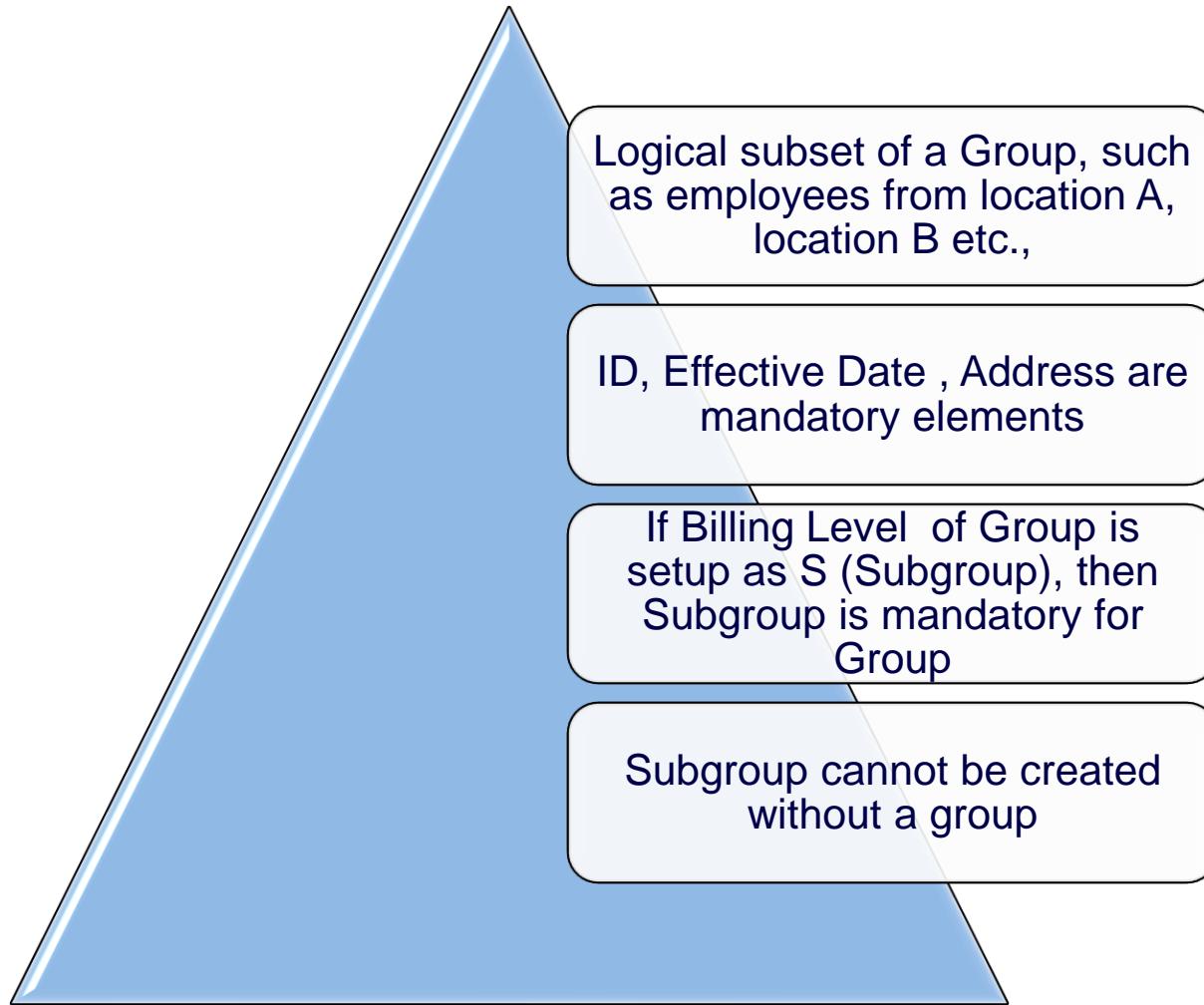
Parent Group



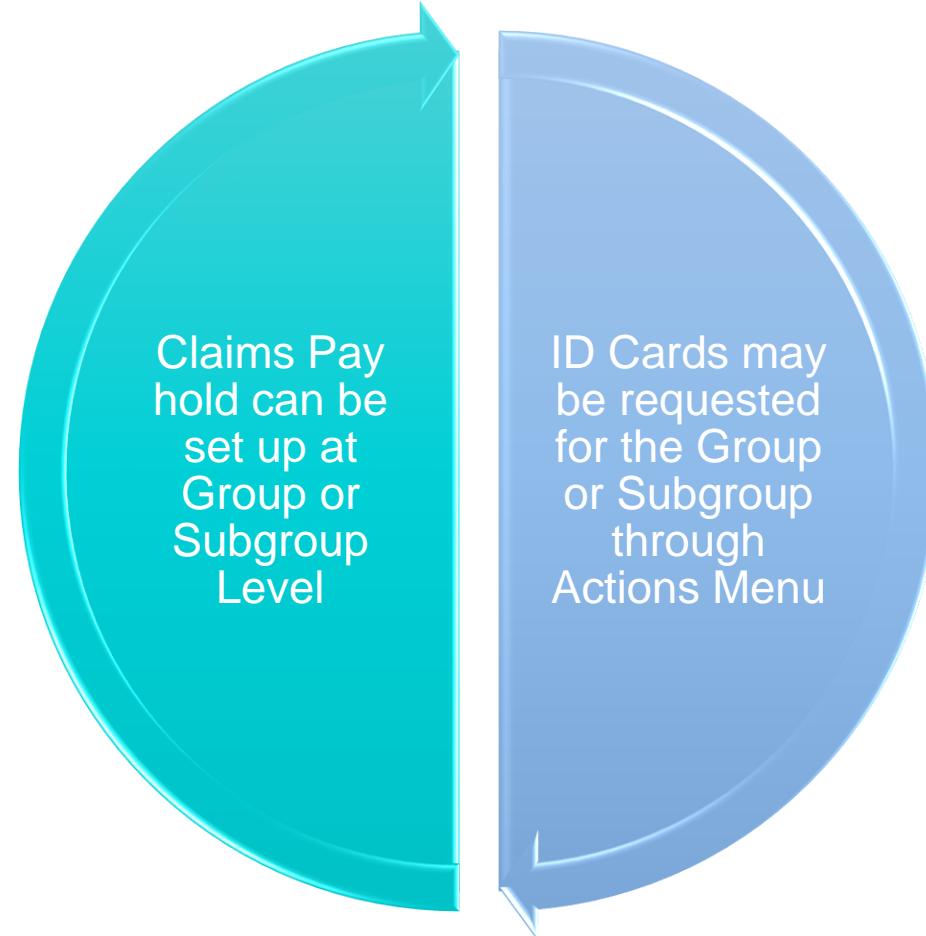
Group



Subgroup



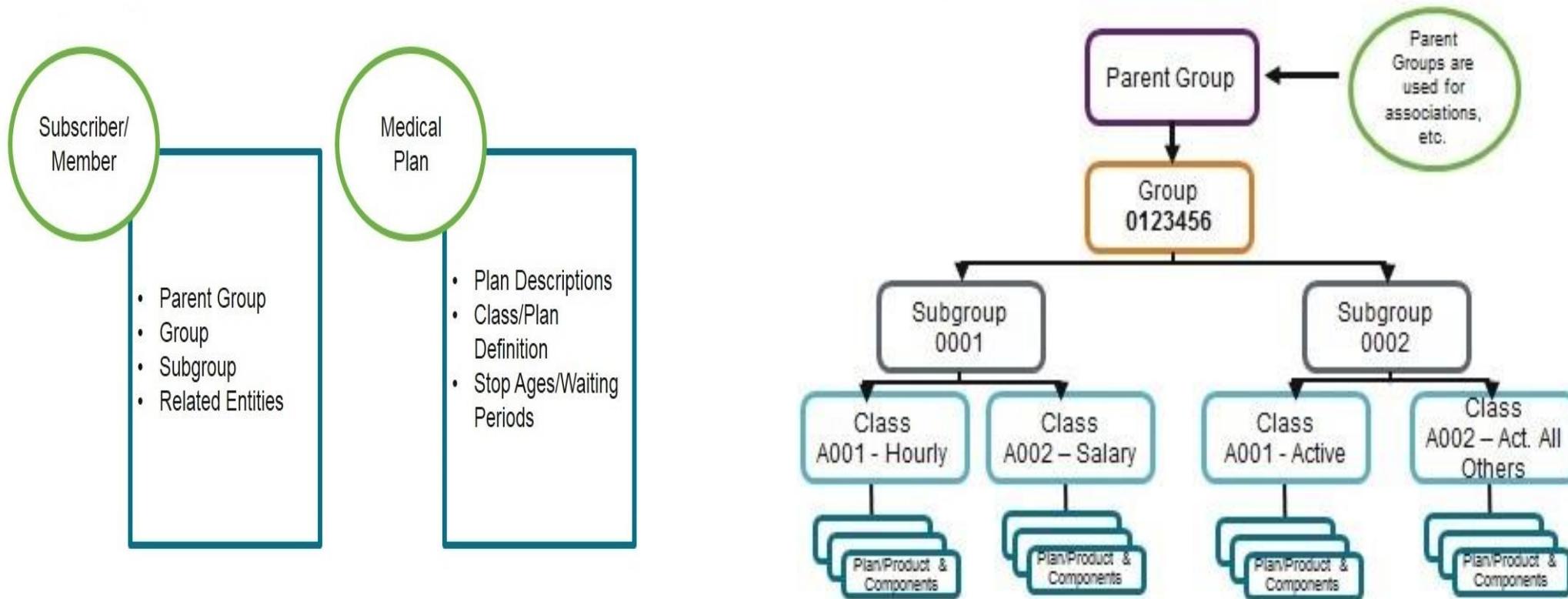
Group / Subgroup



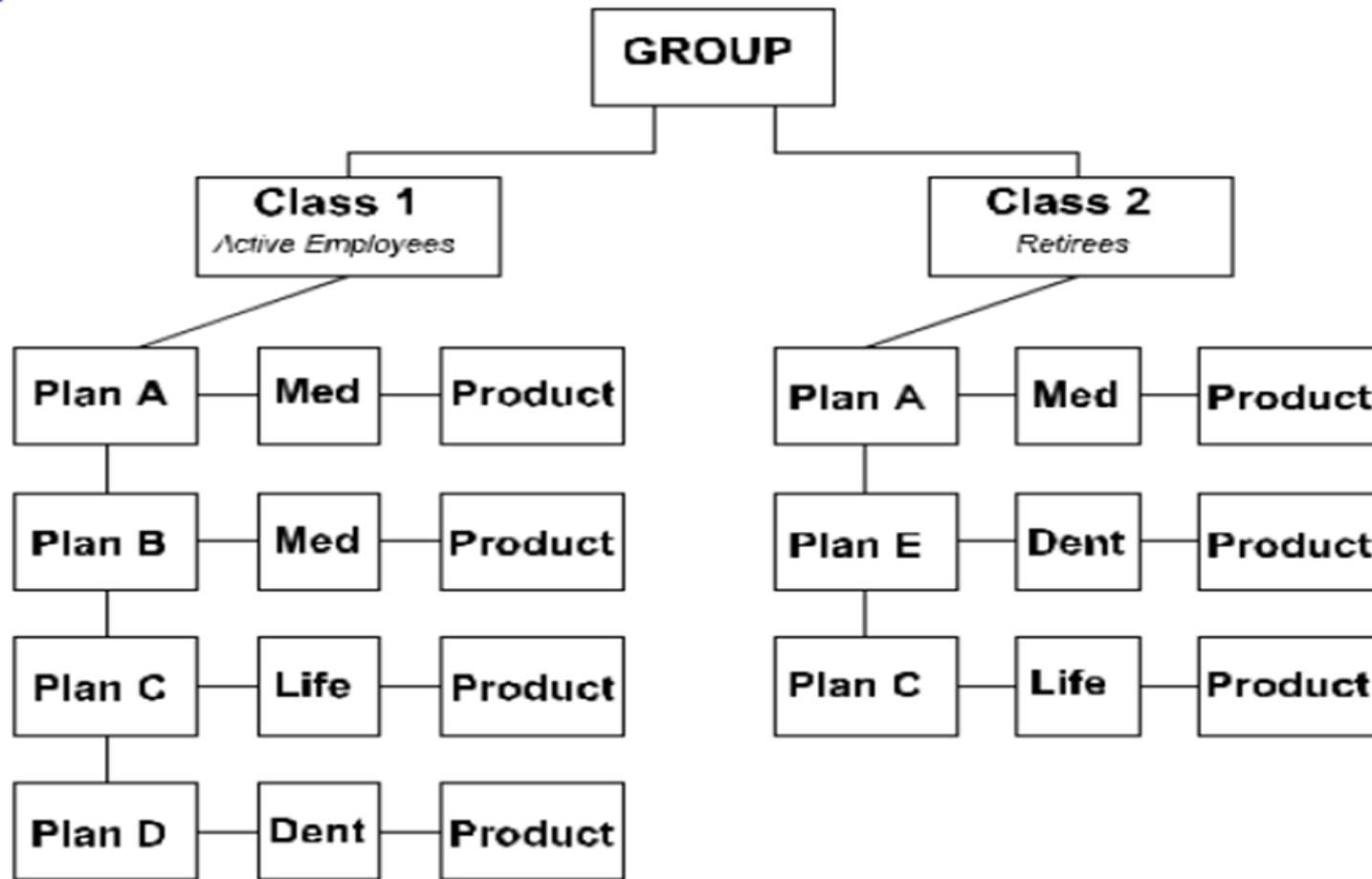


Class Plan

Group Structure



Group Benefit Structure



Class

Indicates classification of Employees/Subscribers under a group.

Group can have more than one class

Service/Procedure/Revenue Conversion prefix is tied to Group-Class in Class/Plan Definition application.

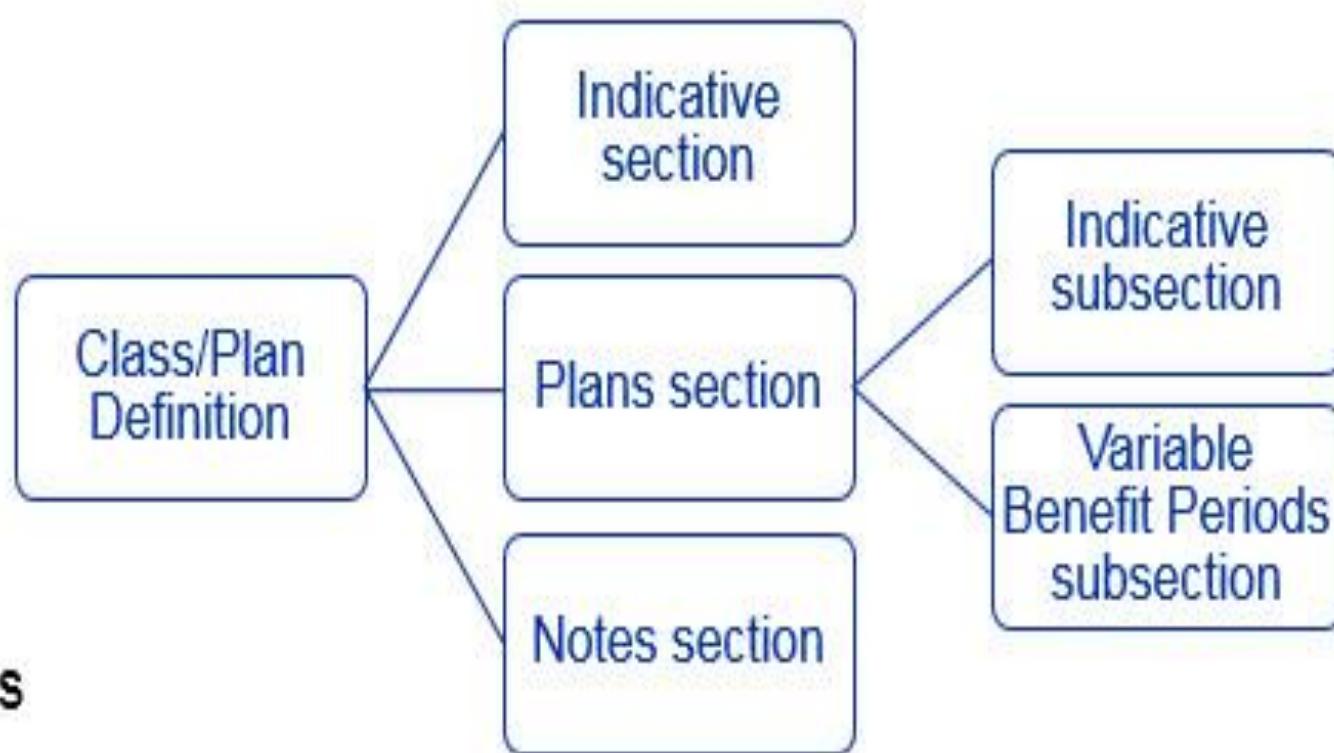
- The Prefix ID for the SECT (Service Code Conversion), TPCT (Service/Procedure Conversion) and RCCT (Service/Revenue Code Conversion) must all be identical since they are identified on the Class/Plan Definition application as a single value (0001)

Plan is associated to a Group–Class combination

Creating a Class

Class/Plan Definition application:

- Indicative section
- Plans section
 - Indicative
 - Variable Benefit Periods
- Notes section



Plan

Plan is defined in Plan Descriptions Application. It is just a business name and ID in this application

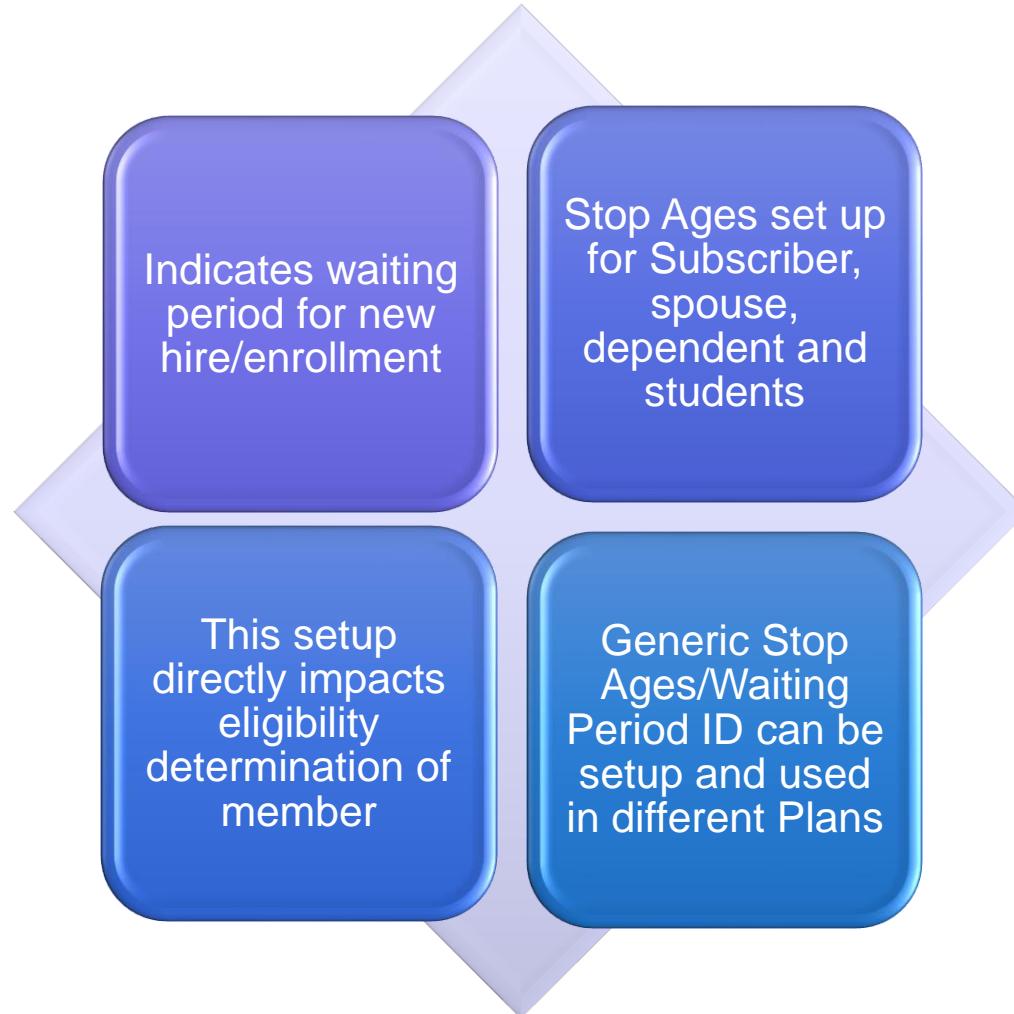
Effective and Term dates are provided for this relationship setup between Group-Class, Plan and Product.

Network Set in this application is the window to Provider section of Facets

Eligibility and covered members details are configured

Stop Ages/Waiting Period ID is tied to Class/Plan definition

Stop Ages/Waiting Period



Network Set

Define the specific networks that are considered in network or participating for a product



These networks can be specific to a benefit product and/or a network provider relationship



Facets matches Network from Network Set and Network relation of Provider to get Provider status



The order of the rows in Network set is important as the matching routine runs through each row and stops with the first match





Questions?



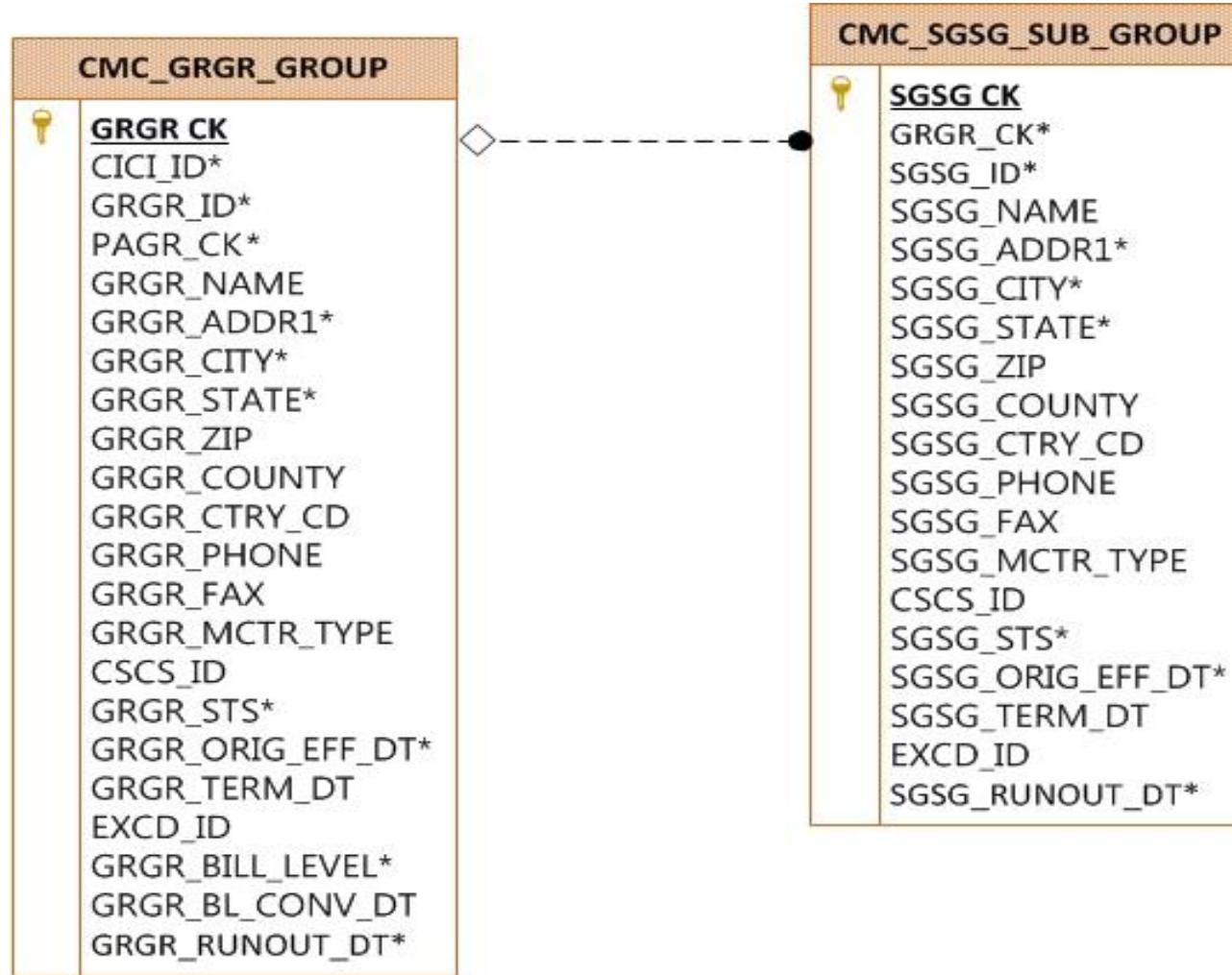
Thank you

Appendix

Group Table

CMC_GRGR_GROUP	
	<u>GRGR_CK</u>
	CICI_ID*
	GRGR_ID*
	PAGR_CK*
	GRGR_NAME
	GRGR_ADDR1*
	GRGR_CITY*
	GRGR_STATE*
	GRGR_ZIP
	GRGR_COUNTY
	GRGR_CTRY_CD
	GRGR_PHONE
	GRGR_FAX
	GRGR_MCTR_TYPE
	CSCS_ID
	GRGR_STS*
	GRGR_ORIG_EFF_DT*
	GRGR_TERM_DT
	EXCD_ID
	GRGR_BILL_LEVEL*
	GRGR_BL_CONV_DT
	GRGR_RUNOUT_DT*

Subgroup Table



Class Plan Table

CMC_CSPI_CS_PLAN	
	<u>GRGR CK</u>
	<u>CSCS ID</u>
	<u>CSPD CAT</u>
	<u>CSPI ID</u>
	<u>CSPI EFF DT</u>
	CSPI_TERM_DT
	PDPD_ID
	CSPI_SEL_IND
	CSPI_FI
	NWST_PFX
	WMDS_SEQ_NO
	CSPI_OPEN_BEG_MMDD
	CSPI_OPEN_END_MMDD
	GPAI_ID
	CSPI_AGE_CALC METH
	CSPI_MCTR_CTYP
	CVST_PFX
	HSAI_ID
	GRDC_PFX
	UTED_PFX



Facets Database Fundamentals

Learning Services



Lesson Objectives

Upon completion of this session, you will be able to:

- Facets Data Model
- Data Types
- Database Terms and Common Columns
- Tables and Keys
- Facets Naming Convention
- Data Dictionary
- Group, Class, Plan, Product – Data Model
- Plan – Data Model
- Subscriber Member – Data Model
- Provider – Data Model
- Claims and Accounting – Data Model



Facets Data Model

Facets Data Model

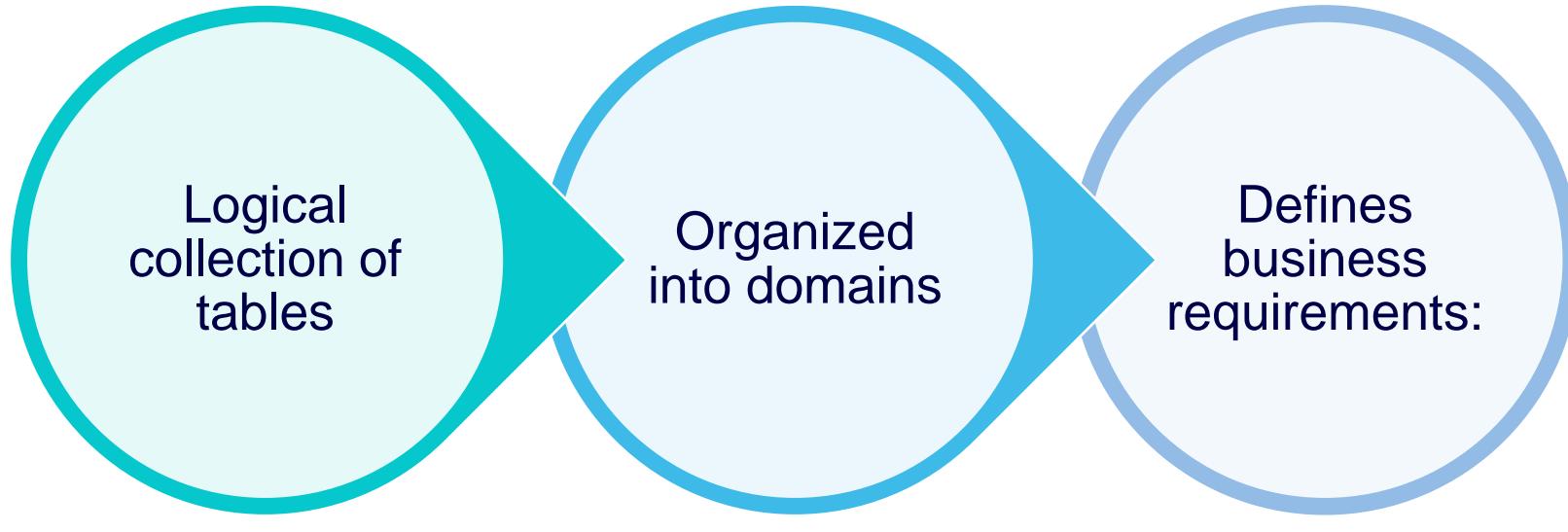


Data models are often used as an aid to communication between the business people defining the requirements for a computer system and the technical people defining the design in response to those requirements.

They are used to show the data needed and created by business processes and organizes data elements and standardizes how the data elements relate to one another.

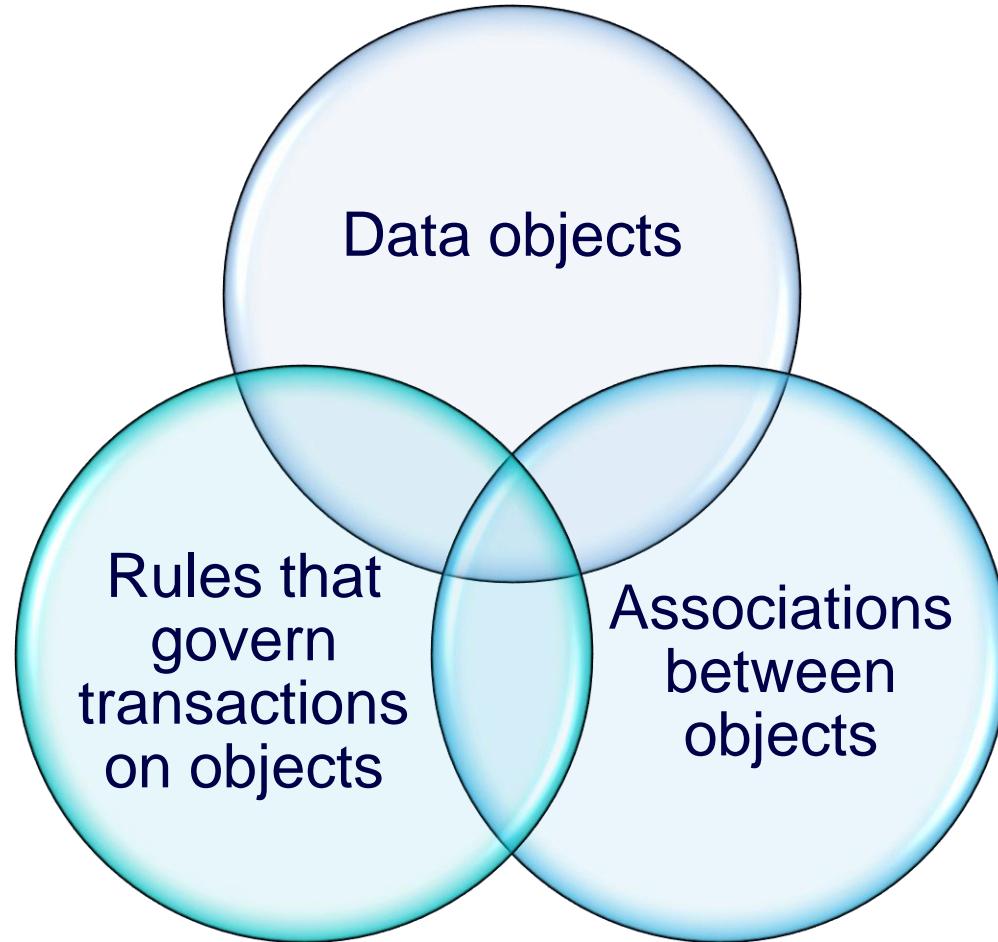
Facets uses an Entity-Relationship Diagram (ERD) type of Data Model.

Facets Data Model



- Addition of rules
- Establish processes

Facets Domains



Database Terms

Common relational database terms:

Entity	Main Object
Instance	Unique Occurrence
Attribute	Description
Attribute Type	Type of Data
Relationship	Association between entities

Data Types

- Determine the allowable form of the data that it can store
- Common values:
 - char
 - varchar
 - int
 - smallint
 - datetime

Default Values

Numeric



Character



Char field : Default Value all spaces / NULL

Default Values Contd..

Datetime (MM/DD/CCYY HH:MM:SS.000)

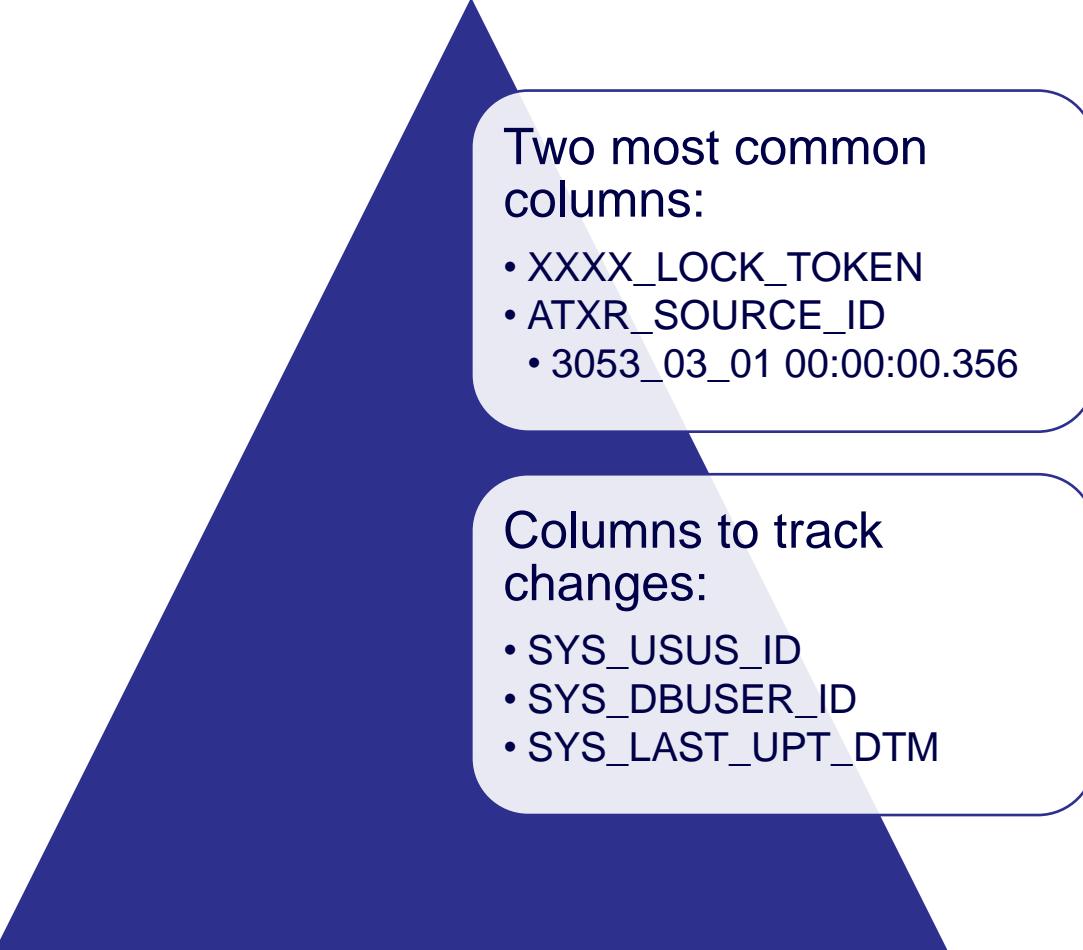
Examples of default Datetime

Effective Date : 01/01/1753 00:00:00.000
01/01/1920 00:00:00.000

Term Date : 12/31/9999 00:00:00.000
12/31/2199 00:00:00.000



Common Columns



Two most common columns:

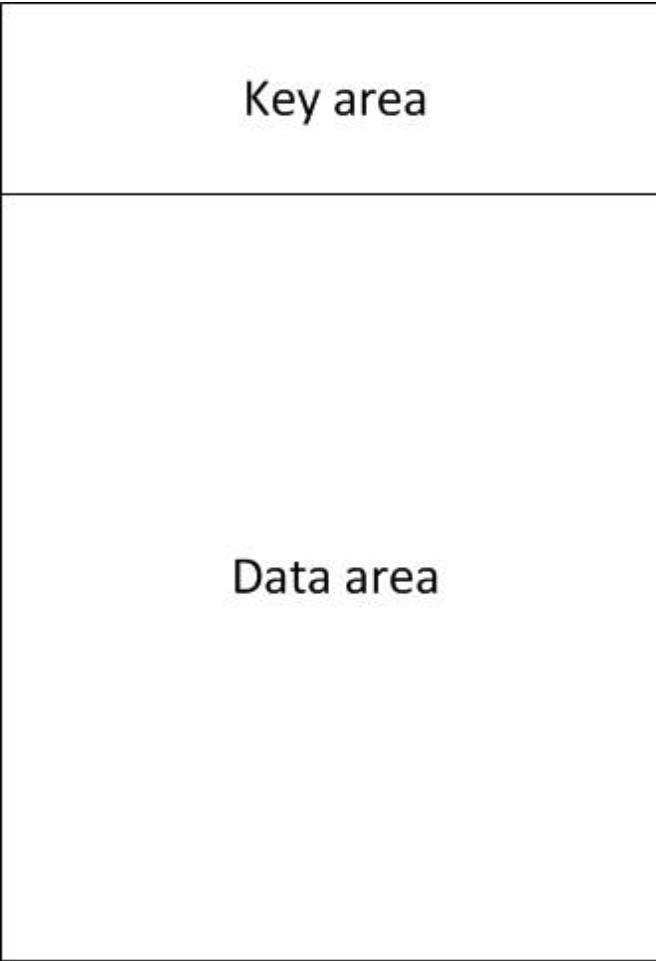
- XXXX_LOCK_TOKEN
- ATXR_SOURCE_ID
- 3053_03_01 00:00:00.356

Columns to track changes:

- SYS_USUS_ID
- SYS_DBUSER_ID
- SYS_LAST_UPD_DTM

Tables and Keys

The Horizontal Line in the Table divides Keys and Non-Keys



Primary and Foreign Keys

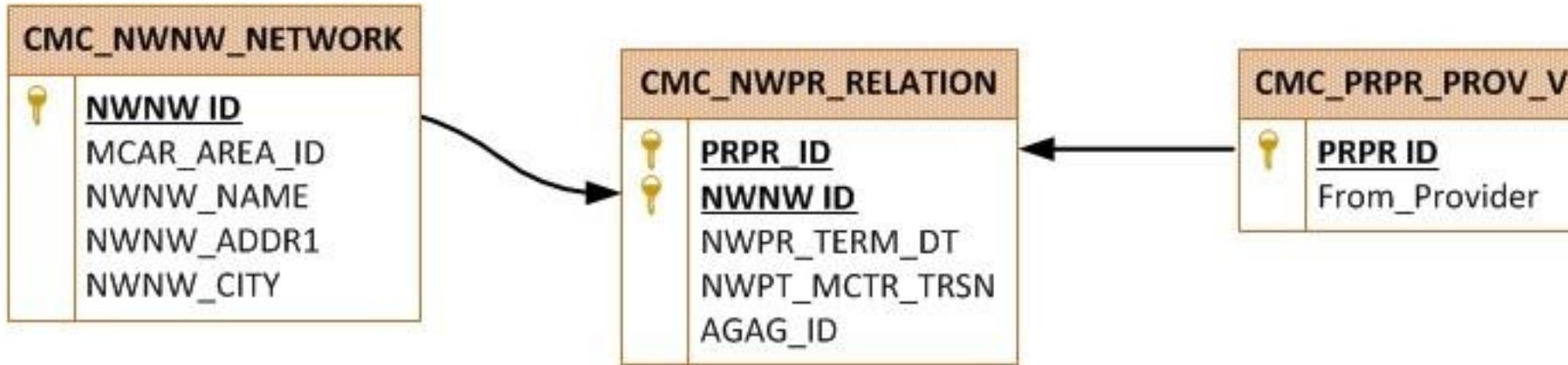
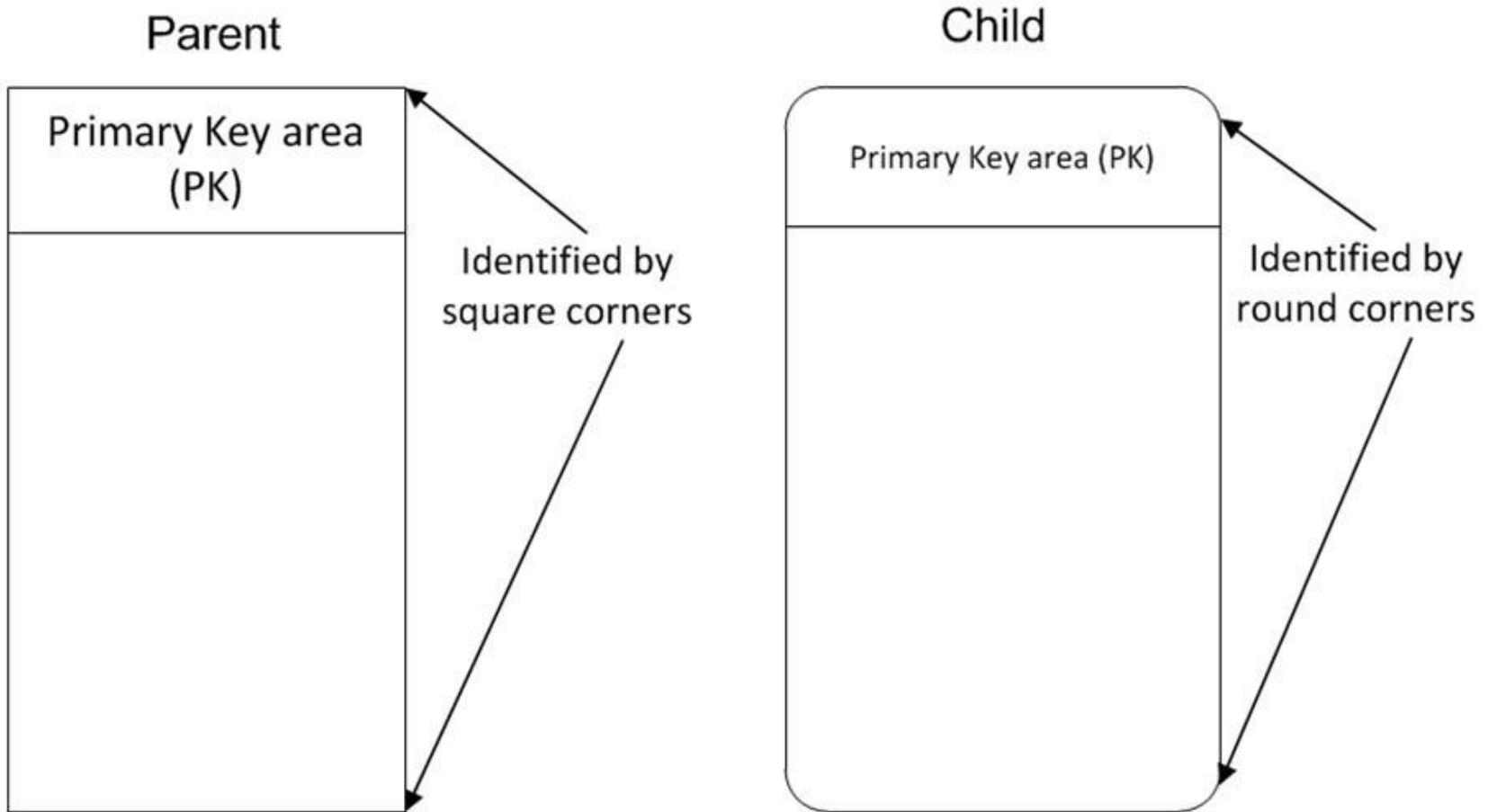
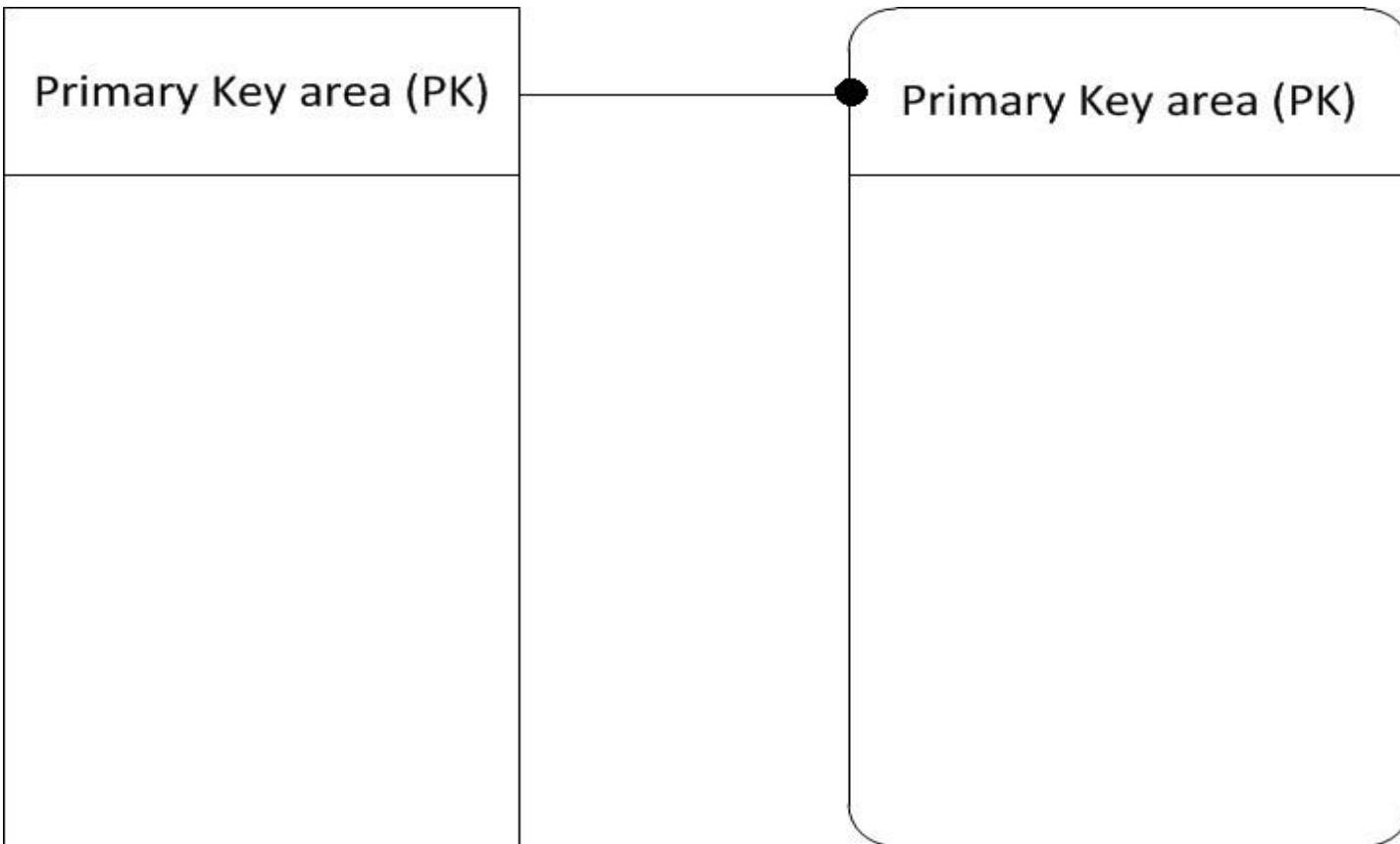


Table Types

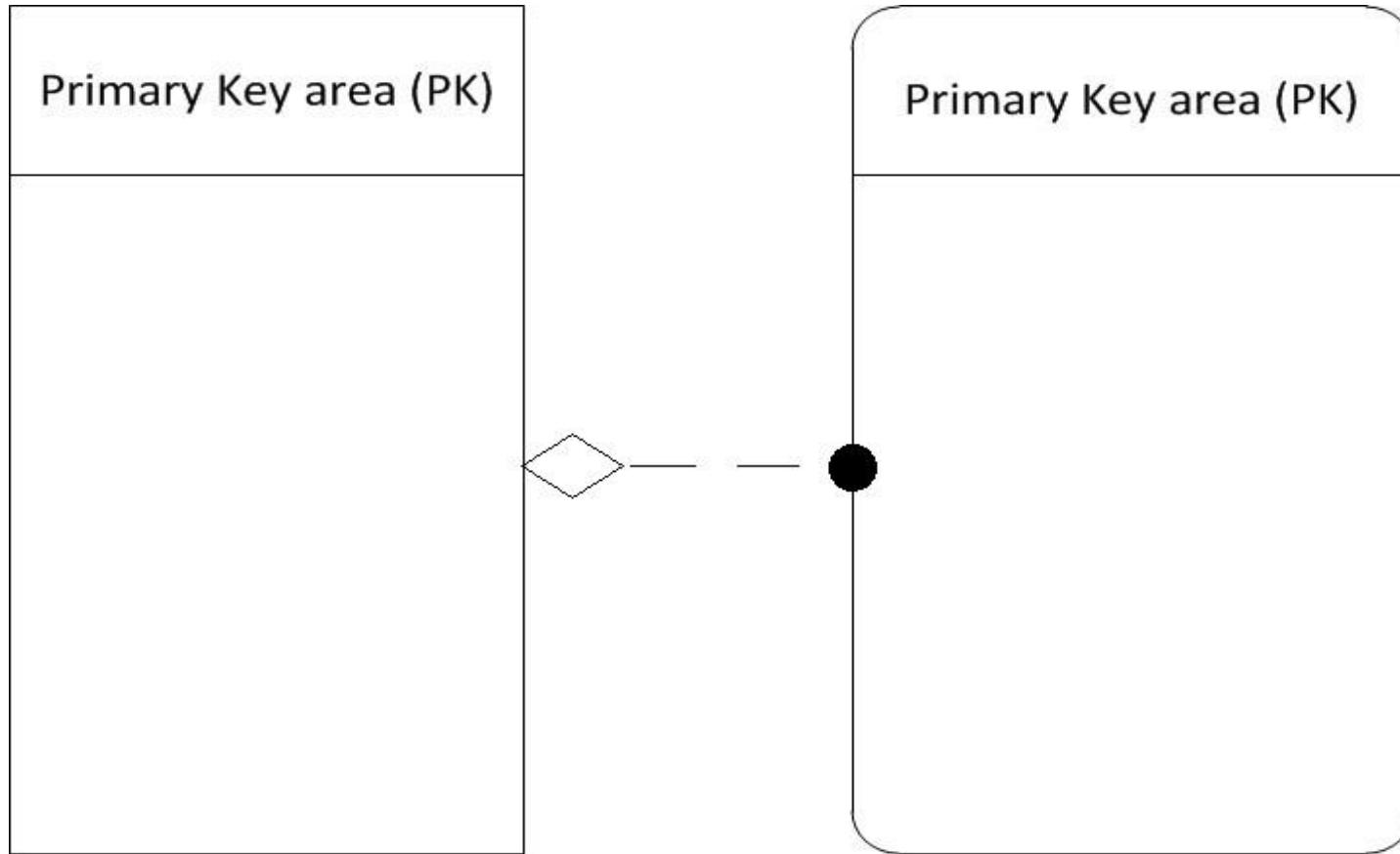


Identifying Relationship



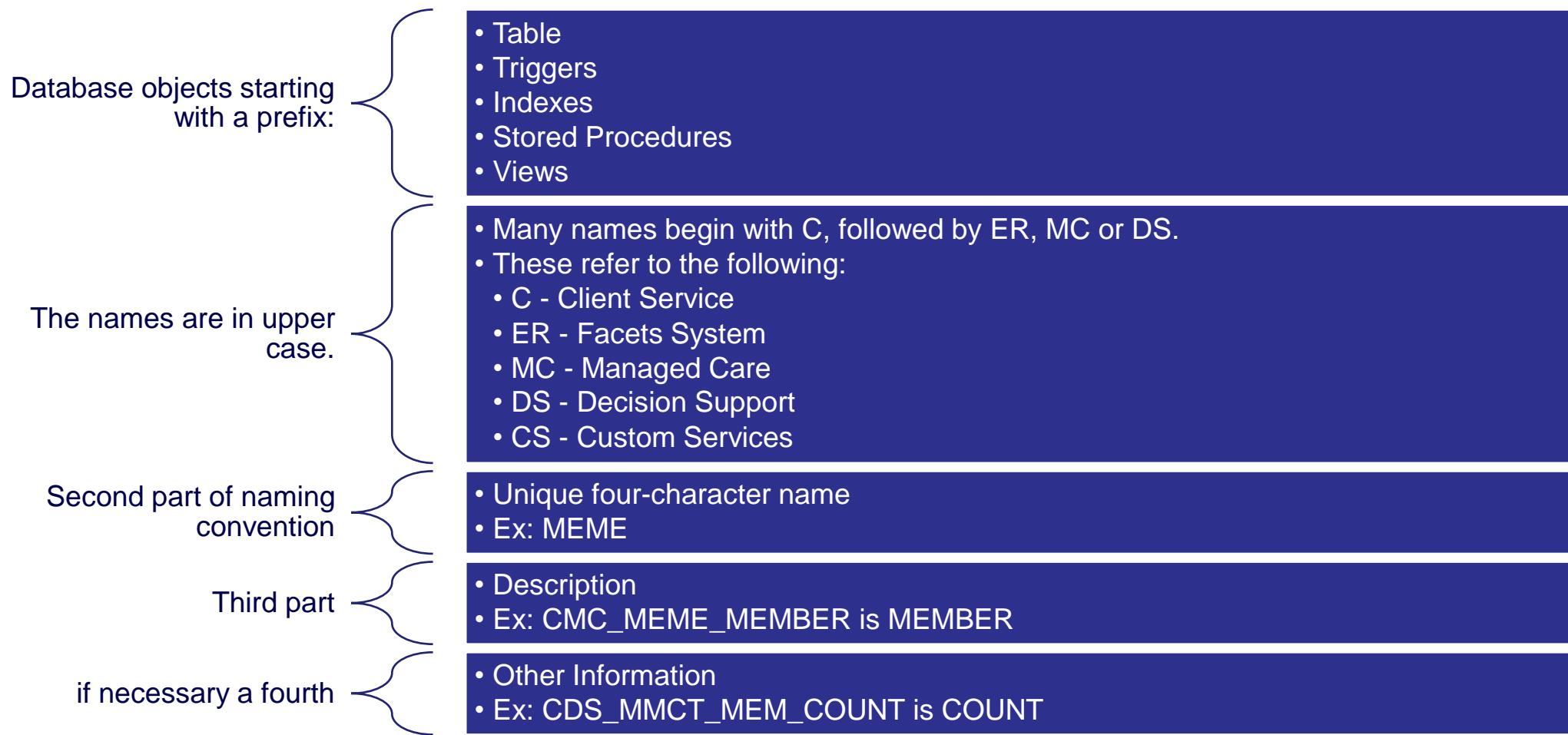
Identifying Relationship (Required)

Non-identifying Relationship



Non-Identifying (Optional)

Facets Naming Convention

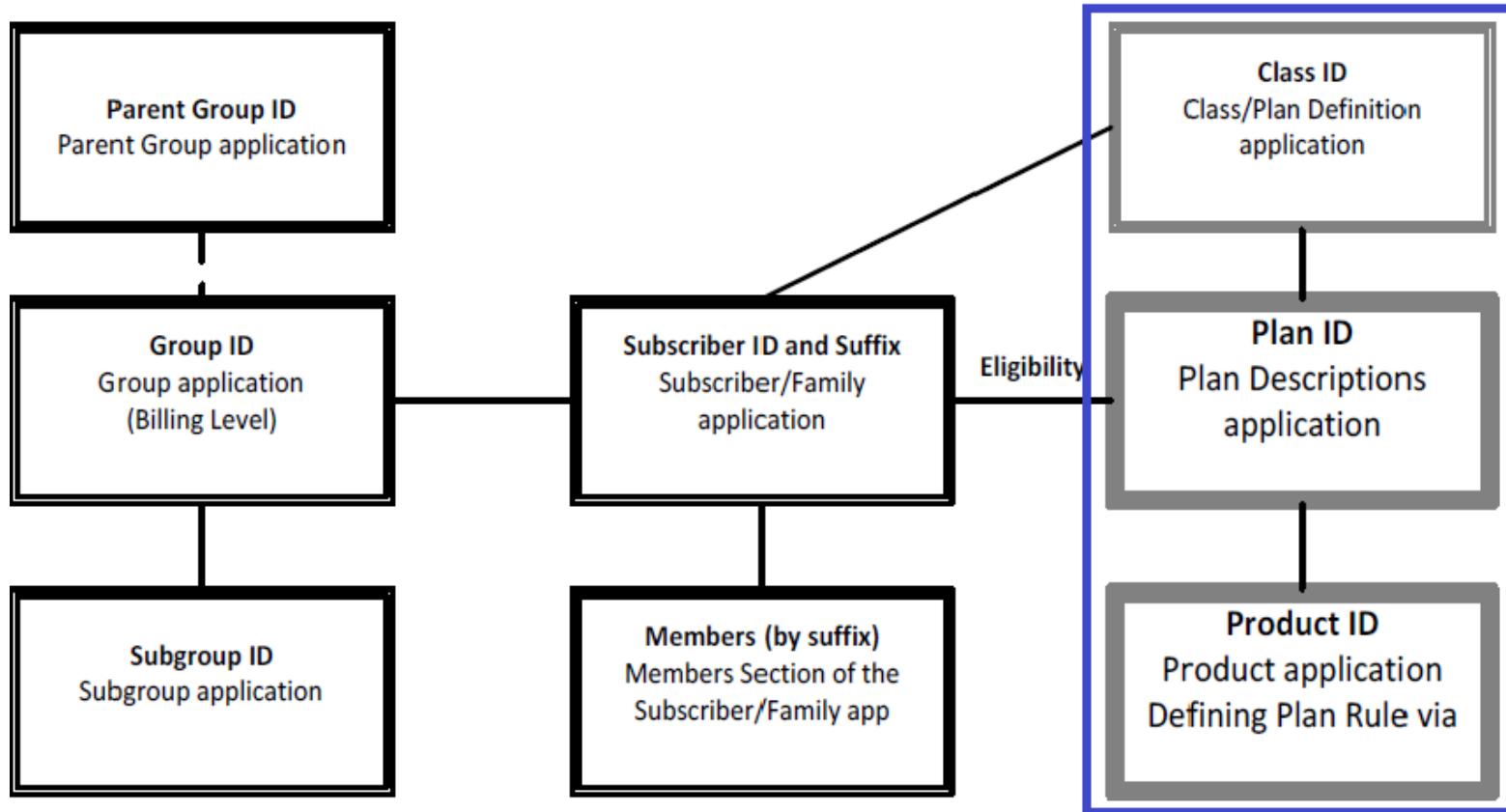


Data Dictionary

- Central source of database information
- For reference, training, and reporting purposes
- Contains:
 - Metadata
 - Table and column definitions
 - Help text
 - Valid values
 - Attributes, key, and GUI information

Group, Class, Plan, Product – Data Model

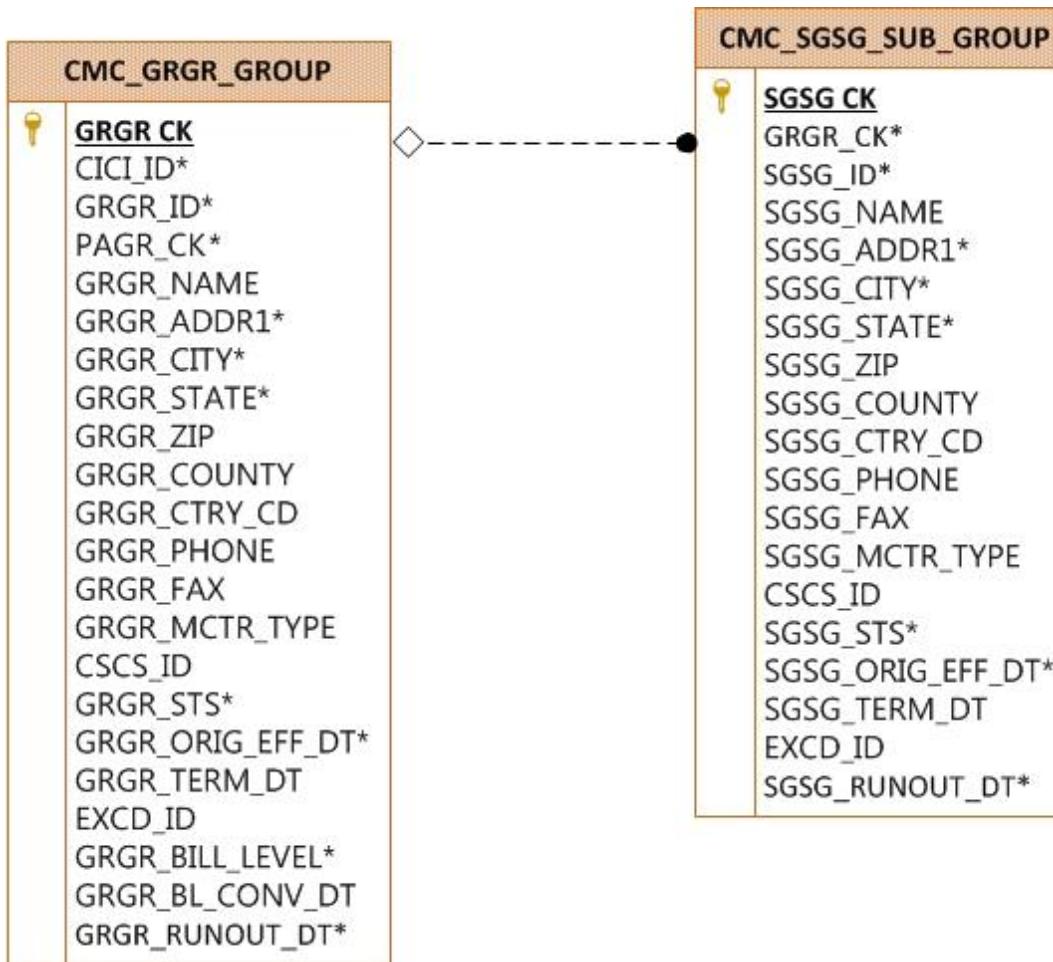
Group, Class, Plan, Product Structure



Group Table

CMC_GRGR_GROUP	
	 GRGR_CK
	CICI_ID*
	GRGR_ID*
	PAGR_CK*
	GRGR_NAME
	GRGR_ADDR1*
	GRGR_CITY*
	GRGR_STATE*
	GRGR_ZIP
	GRGR COUNTY
	GRGR_CTRY_CD
	GRGR_PHONE
	GRGR_FAX
	GRGR_MCTR_TYPE
	CSCS_ID
	GRGR_STS*
	GRGR_ORIG_EFF_DT*
	GRGR_TERM_DT
	EXCD_ID
	GRGR_BILL_LEVEL*
	GRGR_BL_CONV_DT
	GRGR_RUNOUT_DT*

Subgroup Table

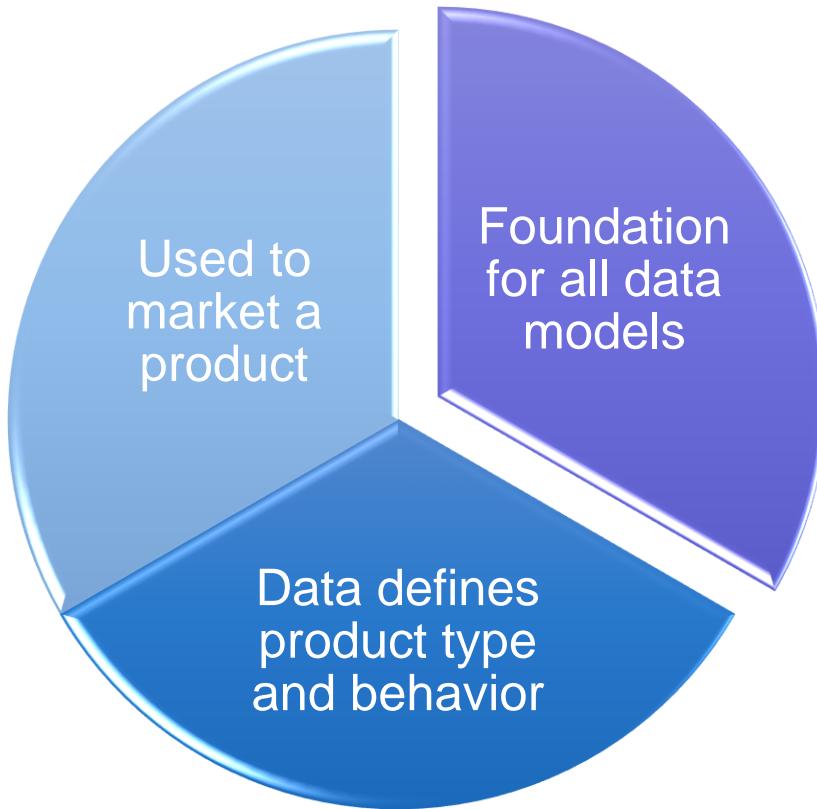


Class Plan Table

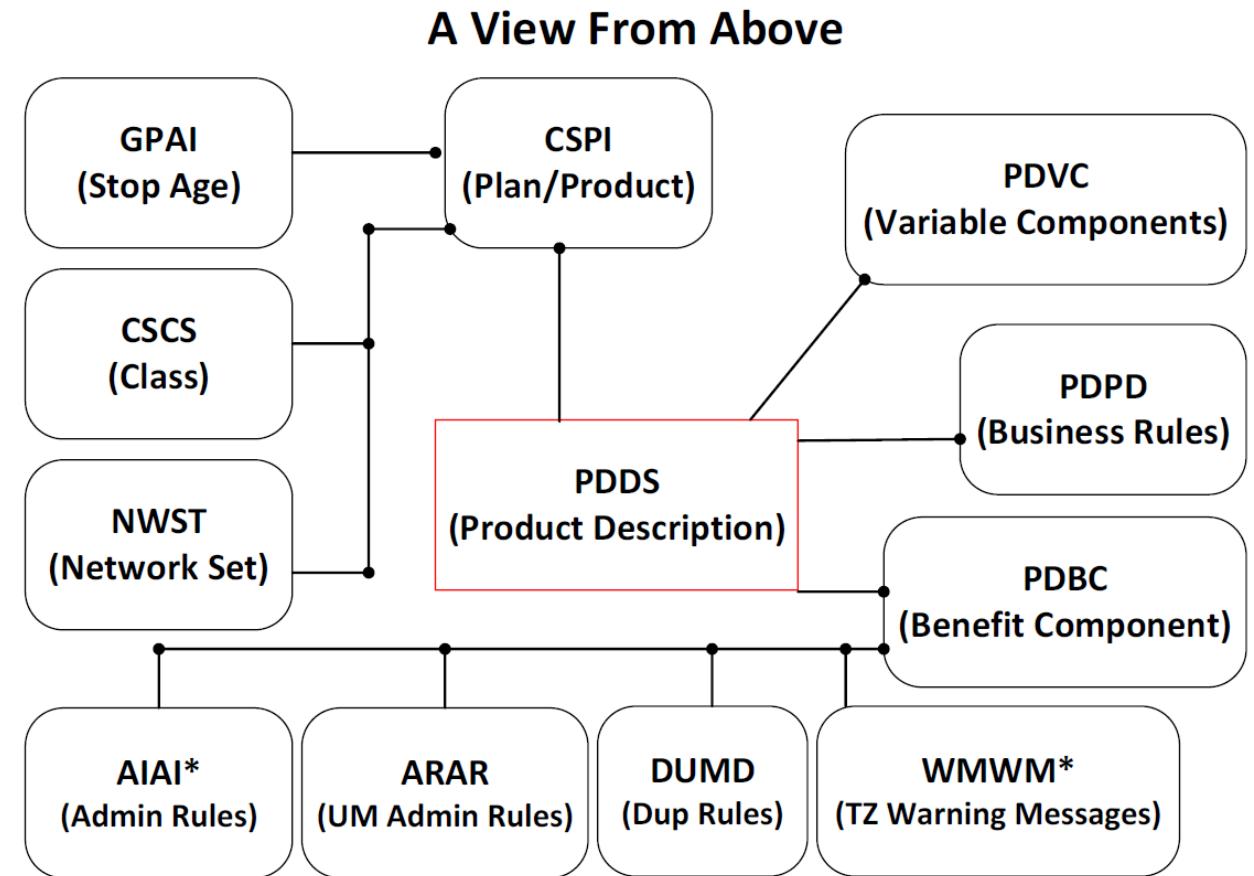
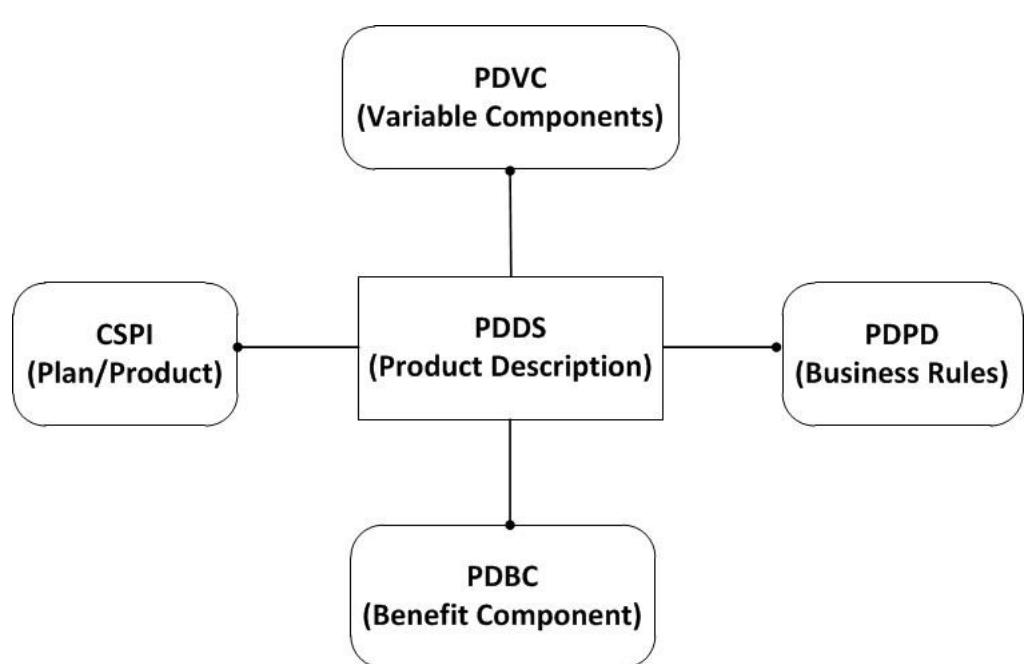
CMC_CSPI_CS_PLAN	
GRGR CK	
CSCS ID	
CSPD CAT	
CSPI ID	
CSPI EFF DT	
CSPI_TERM_DT	
PDPD_ID	
CSPI_SEL_IND	
CSPI_FI	
NWST_PFX	
WMDS_SEQ_NO	
CSPI_OPEN_BEG_MMDD	
CSPI_OPEN_END_MMDD	
GPAI_ID	
CSPI_AGE_CALC METH	
CSPI_MCTR_CTYP	
CVST_PFX	
HSAI_ID	
GRDC_PFX	
UTED_PFX	

Plan – Data Model

Plan Structure



Plan Structure

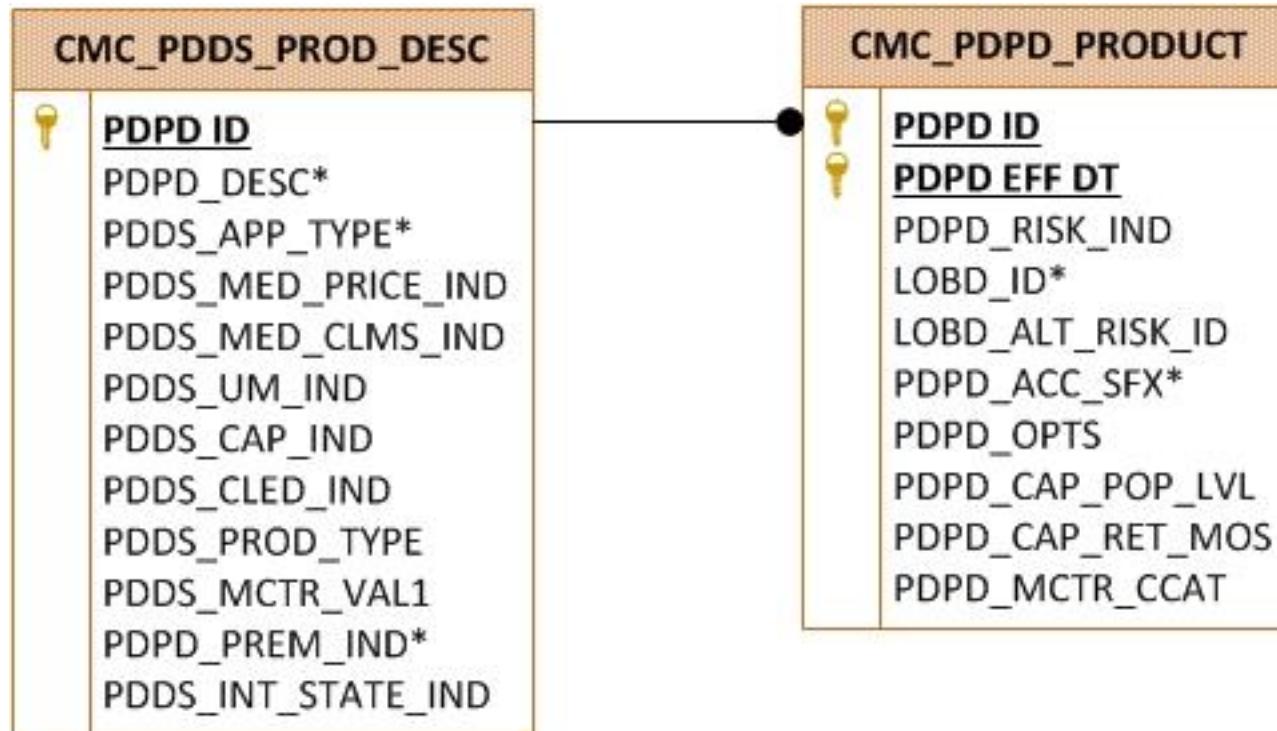


* Required

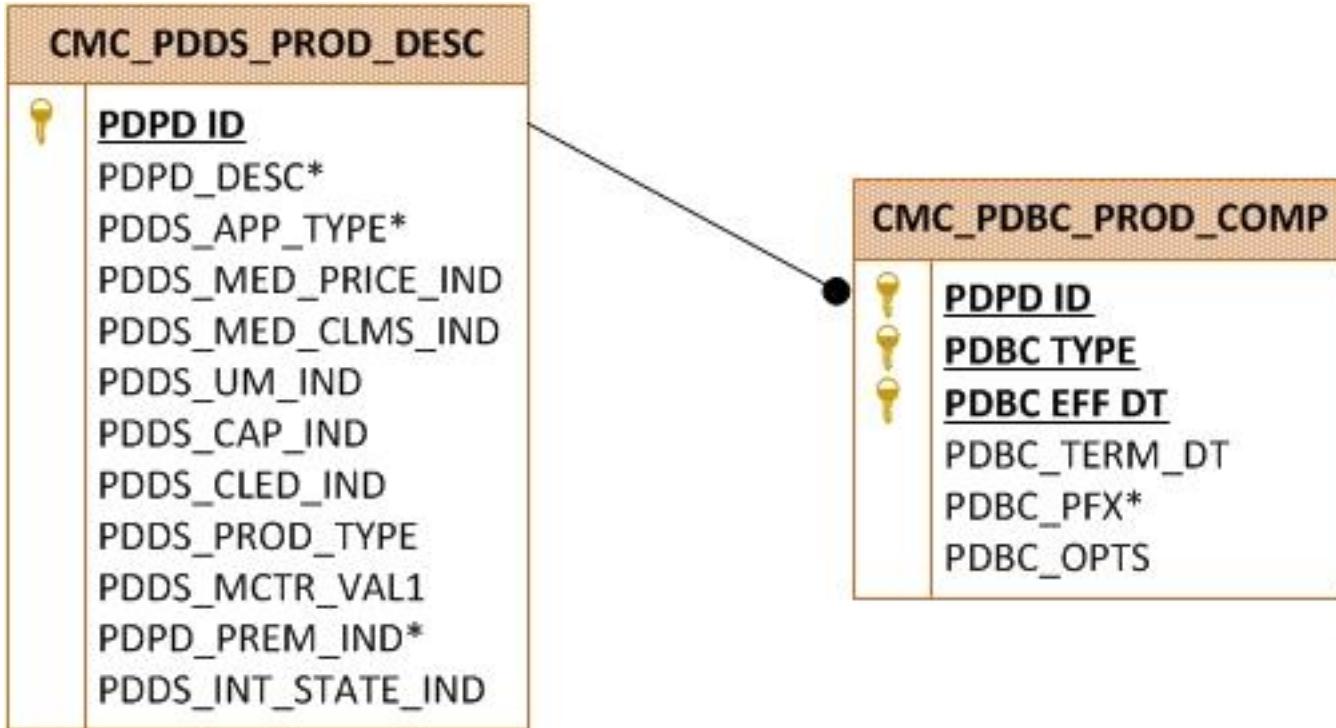
Product Description Table

CMC_PDDS_PROD_DESC	
	<u>PDPD ID</u>
	PDPD_DESC*
	PDDS_APP_TYPE*
	PDDS_MED_PRICE_IND
	PDDS_MED_CLMS_IND
	PDDS_UM_IND
	PDDS_CAP_IND
	PDDS_CLED_IND
	PDDS_PROD_TYPE
	PDDS_MCTR_VAL1
	PDPD_PREM_IND*
	PDDS_INT_STATE_IND

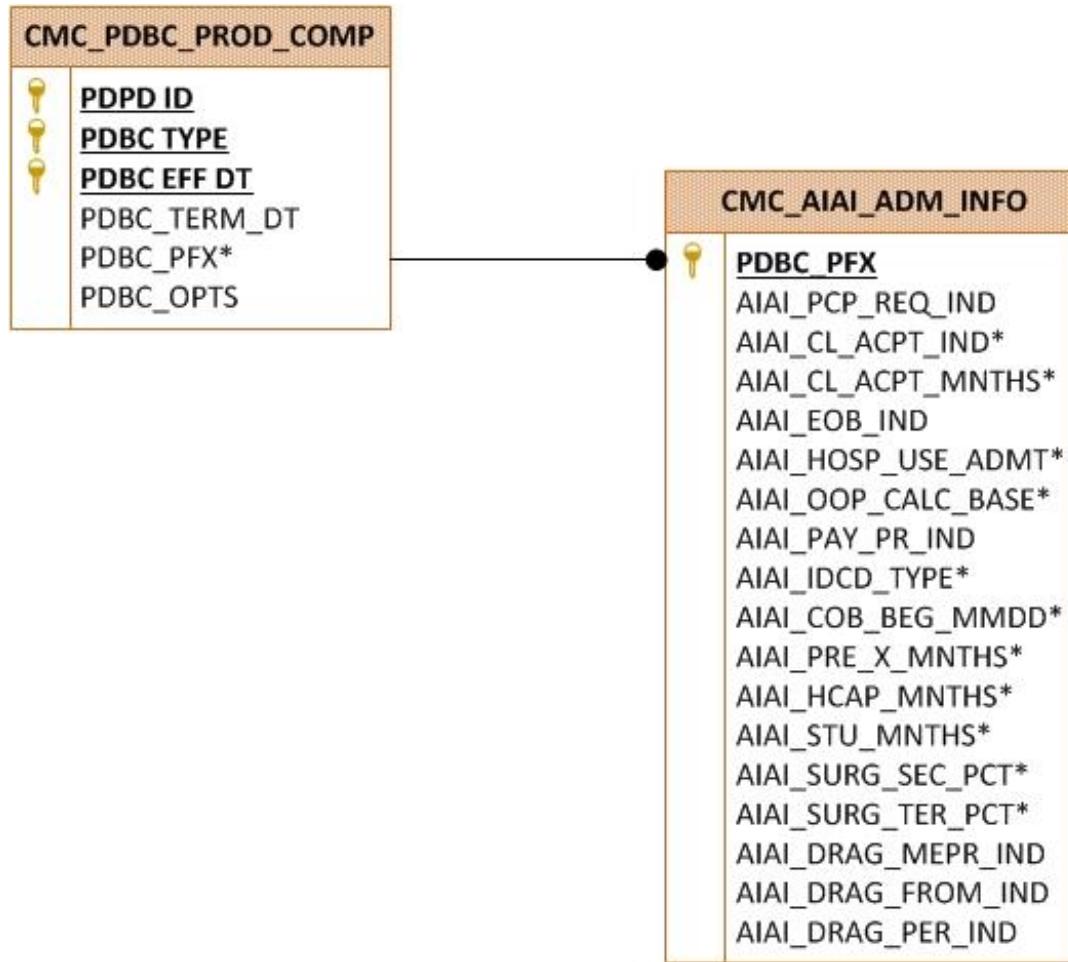
Product Table



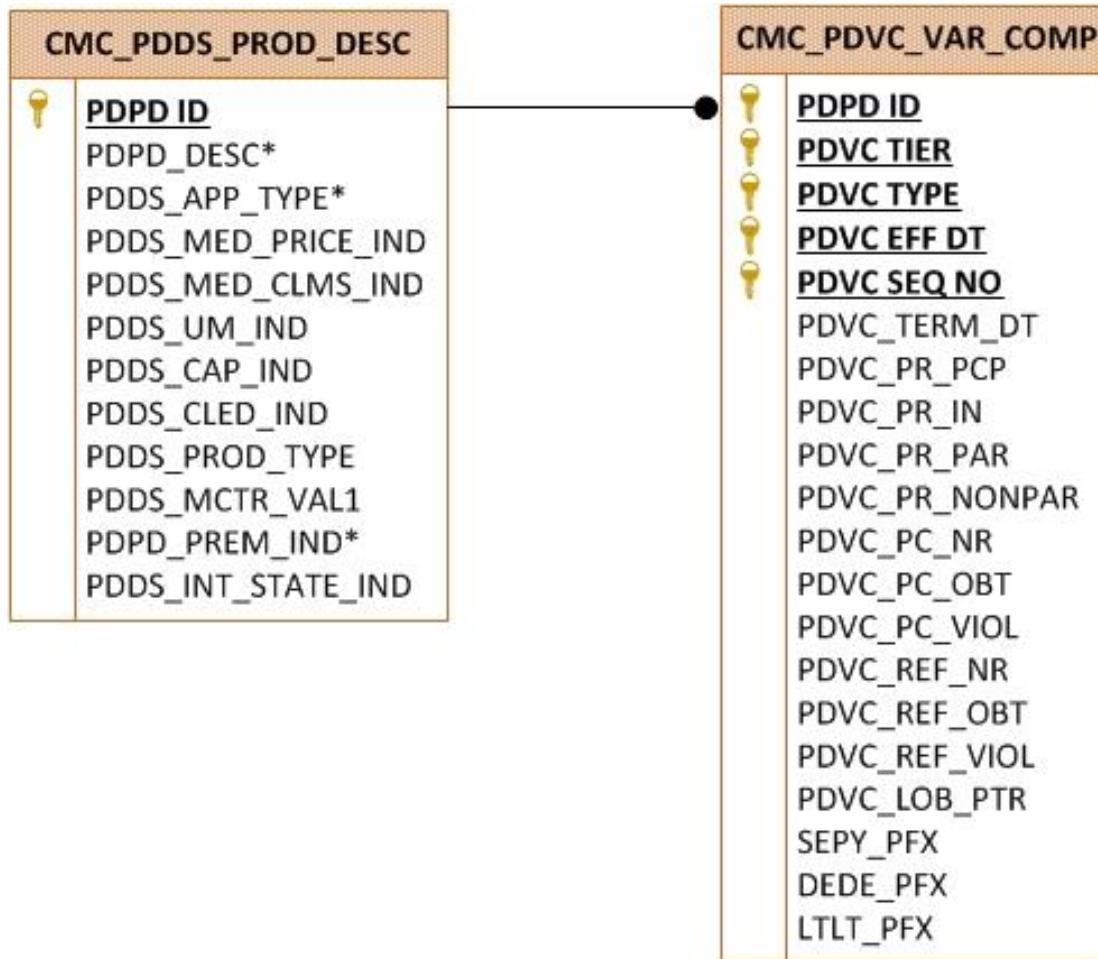
Benefit Components Table



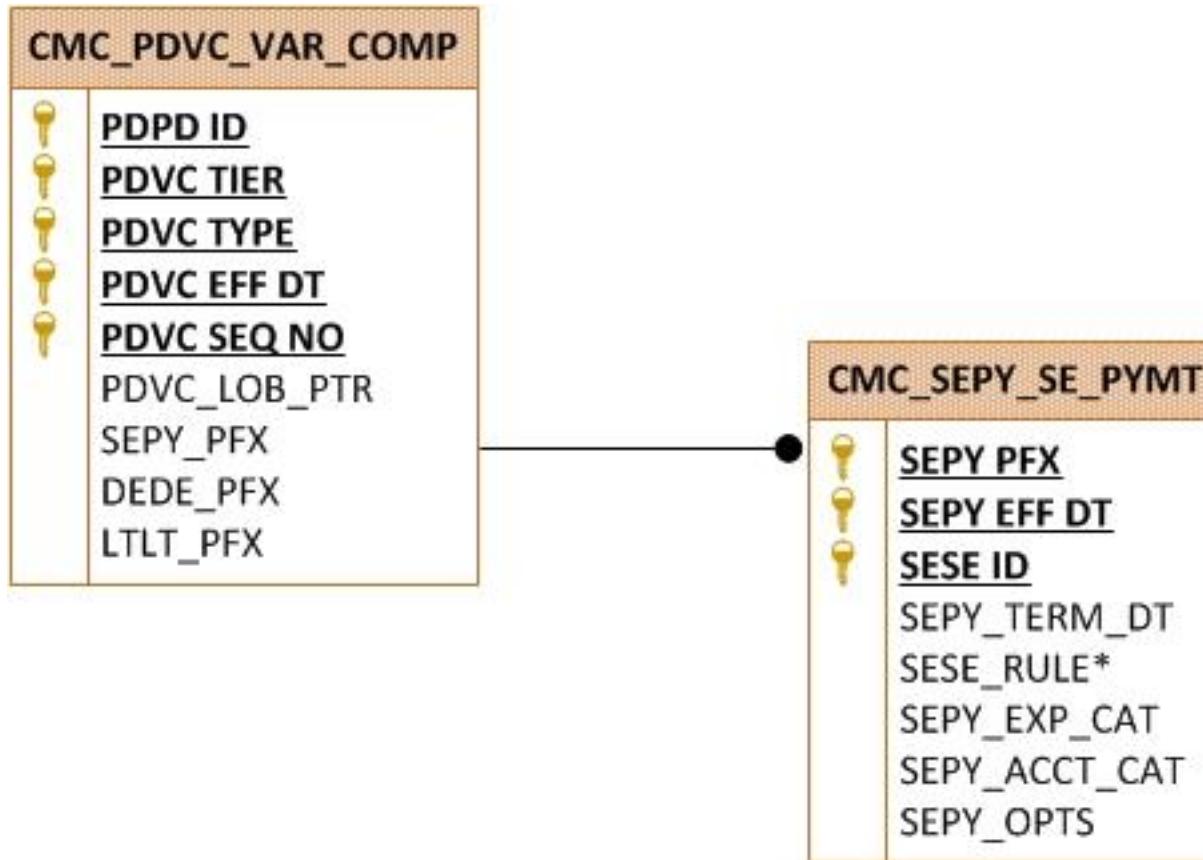
Administrative Information Table



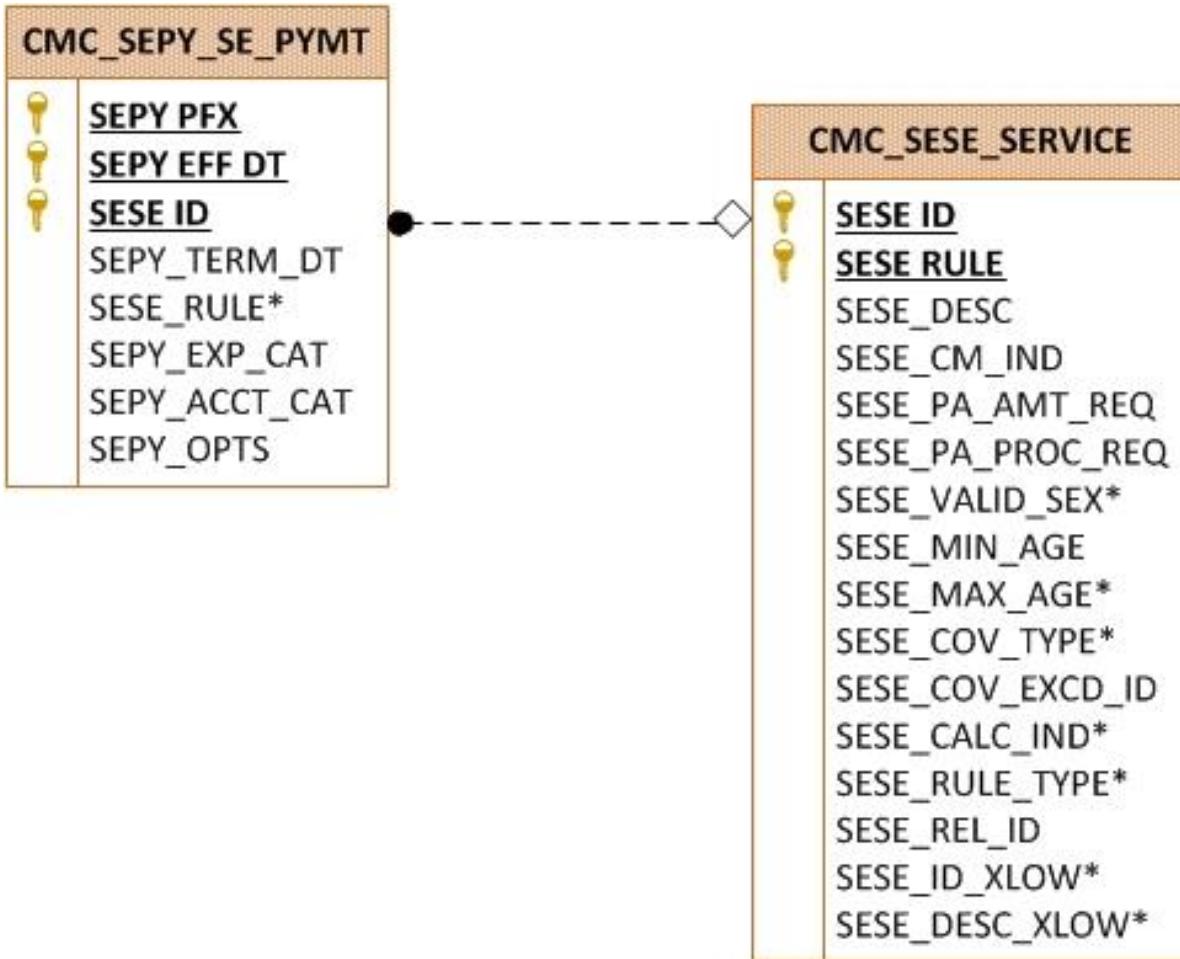
Variable Components Tables



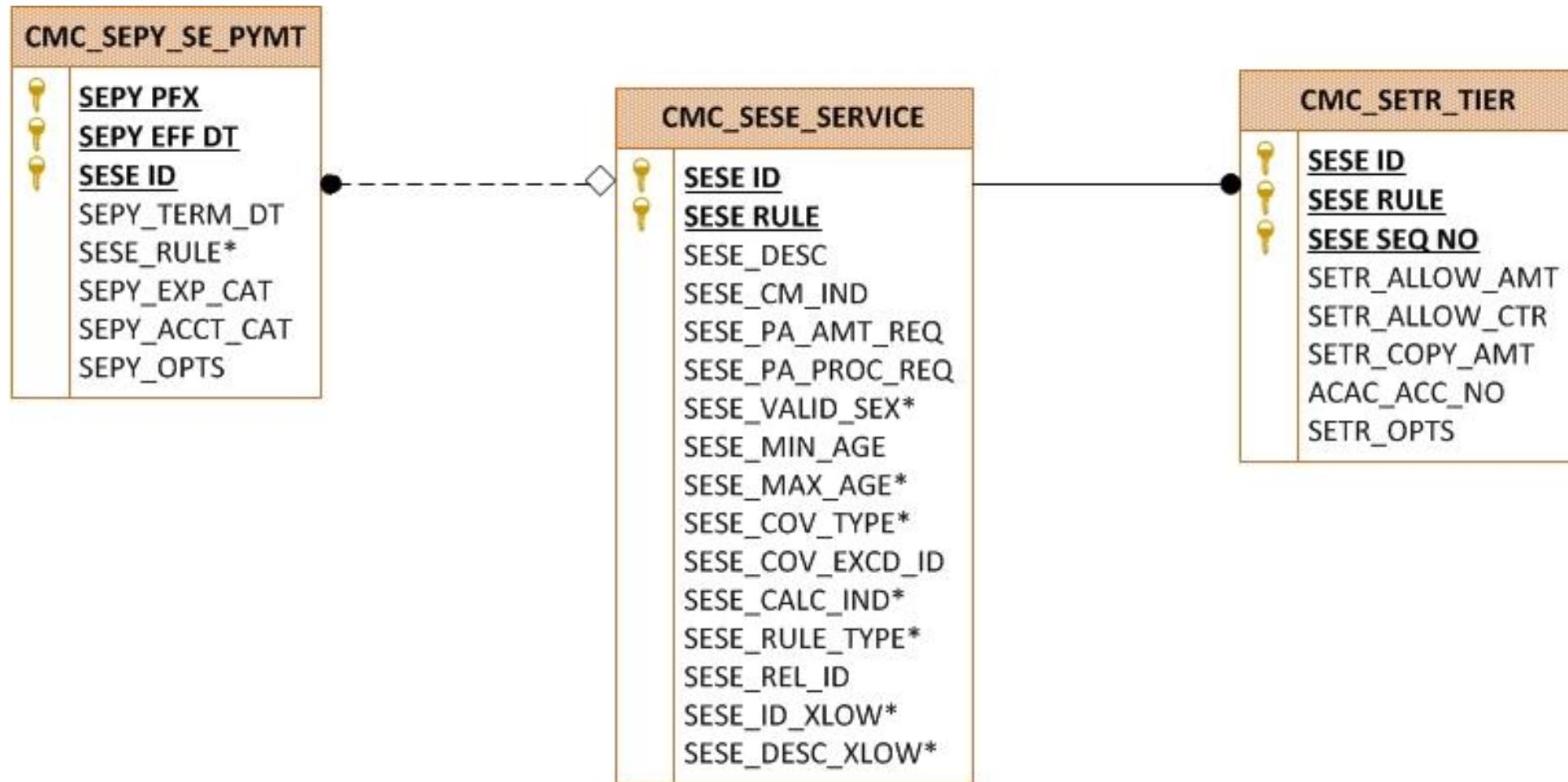
Service Payment Table



Service Rule Definition Table

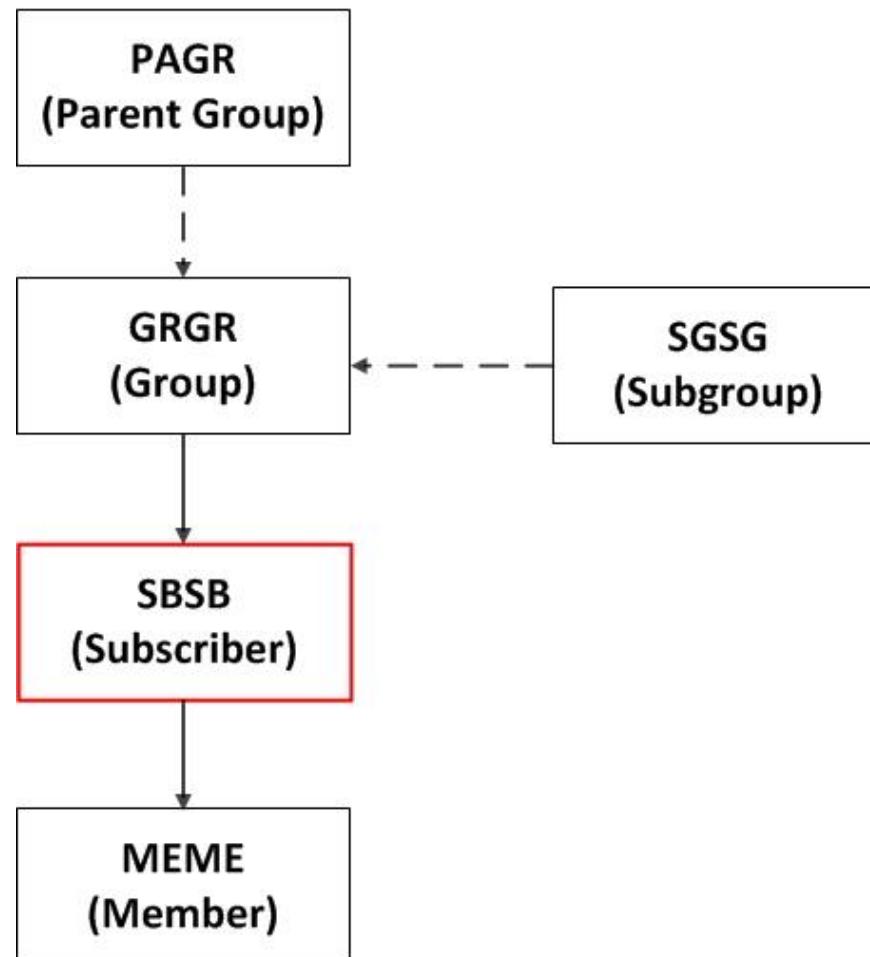


Service Tier Table

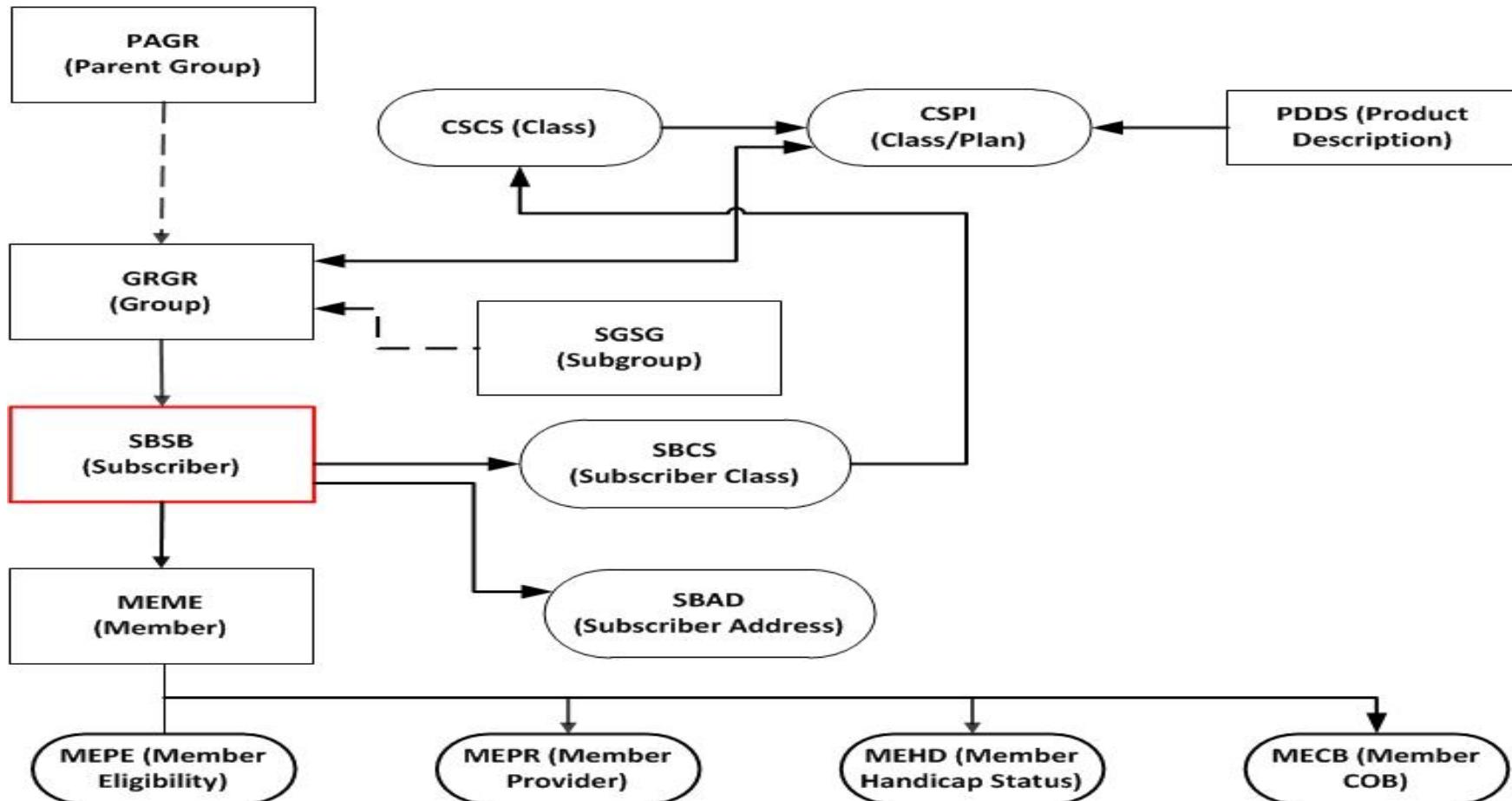


Subscriber Member – Data Model

Subscriber Member Structure



Subscriber Member Structure Contd..



Subscriber Indicative Table

CMC_SBSB_SUBSC	
	SBSB CK GRGR_CK* SBSB_ID* SBSB_LAST_NAME* SBSB_FIRST_NAME* SBSB_MID_INIT SBSB_ORIG_EFF_DT* SBSB_MCTR_STS SBSB_MCTR_VIP SBSB_EMPLOY_ID SBSB_HIRE_DT SBSB_RETIRE_DT SBSB_FI* SBSB_PAY_CL METH* SBSB_TYPE_HOME* SBSB_TYPE_MAIL SBSB_TYPE_WPRL SBSB_LAST_NAME_XLOW*

Subscriber Warning Messages Table

CMC_SBWM_SB_MSG	
	<u>SBSB CK</u>
	<u>SBWM EFF DT</u>
	<u>WMDS SEQ NO</u>
	SBWM_TERM_DT
	SBWM_MCTR_TRSN
	GRGR_CK

Subscriber Relationship Table

CMC_SBSG_RELATION	
	<u>SBSB CK</u>
	<u>SBSG EFF DT</u>
	GRGR_CK
	SGSG_CK
	SBSG_TERM_DT
	SBSG_MCTR_TRSN

Subgroup Class Section

CMC_SGCS_RELATION	
	<u>SGSG CK</u>
	<u>CSCS ID</u>
	<u>SGCS EFF DT</u>
	GRGR_CK
	SGCS_TERM_DT

Subscriber Class Information Table

CMC_SBCS_CLASS	
	<u>SBSB CK</u>
	<u>SBSG EFF DT</u>
	SBCS_TERM_DT
	GRGR_CK
	CSCS_ID

Subscriber Eligibility Table

CMC_SBEL_ELIG_ENT	
	<u>SBSB CK</u>
	<u>SBEL EFF DT</u>
	<u>SBEL INSQ DT</u>
	GRGR_CK
	SBEL_ELIG_TYPE
	CSPD_CAT
	CSPI_ID
	SBEL_FI
	EXCD_ID
	SBEL_MCTR_RSN
	SBEL_VOID_IND
	SBEL_MCTR_ORSN

Member Eligibility Table

CMC_MEEL_ELIG_ENT	
	<u>MEME CK</u>
	<u>MEEL EFF DT</u>
	<u>MEEL INSQ DT</u>
	GRGR_CK
	MEEL_ELIG_TYPE
	CSPD_CAT
	CSPI_ID
	EXCD_ID
	MEEL_MCTR_RSN
	MEEL_VOID_IND
	MEEL_MCTR_ORSN

Member Eligibility Status Table

CMC_MEPE_PRCS_ELIG	
	<u>MEME CK</u>
	<u>CSPD CAT</u>
	<u>MEPE EFF DT</u>
	MEPE_TERM_DT
	MEPE_CREATE_DTM
	CSCS_ID
	GRGR_CK
	SGSG_CK
	CSPI_ID
	PDPD_ID
	MEPE_ELIG_IND
	EXCD_ID
	MEPE_MCTR_RSN
	MEPE_FI

Member PCP Table

CMC_MEPR_PRIM_PROV	
	<u>MEME CK</u>
	<u>MEPR PCP TYPE</u>
	<u>MEPR EFF DT</u>
	MEPR_TERM_DT
	MEPR_MCTR_TRSN
	MEPR_MCTR_ORSN
	MEPR_MCTR_ERSN
	GRGR_CK
	PRPR_ID
	MEPR_SOURCE
	MEPR_DEMGRPHC_IND
	MEPR_CAP_REL_ENT

Member COB Table

CMC_MECB_COB	
	<u>MEME CK</u>
	<u>MECB INSUR TYPE</u>
	<u>MECB INSUR ORDER</u>
	<u>MECB MCTR STYP</u>
	<u>MECB EFF DT</u>
	MECB_TERM_DT
	MECB_MCTR_TRSN
	GRGR_CK
	MCRE_ID
	MECB_POLICY_ID
	MECB_MCTR_MSP
	MECB_RXBIN
	MECB_LAST_VER_DT
	MECB_MCTR_VMTH

Related Entity Table

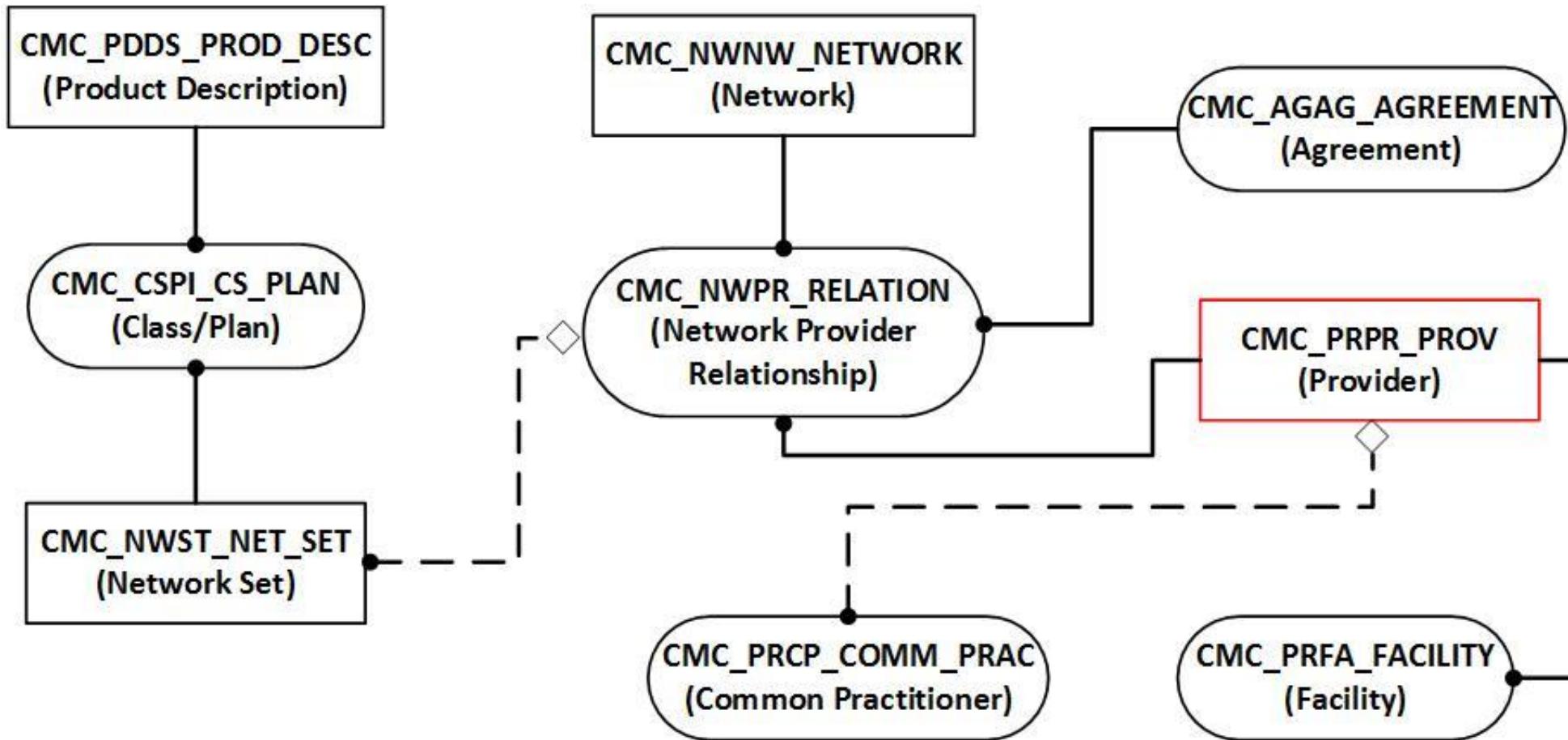
CMC_MCRE_RELAT_ENT	
	<u>MCRE_ID</u>
	MCRE_NAME
	MCRE_TYPE
	MCRE_ADDR1
	MCRE_CITY
	MCRE_STATE
	MCRE_COUNTY
	MCRE_CTRY_CD
	MCRE_PHONE
	MCRE_FAX
	MCRE_MCTR_CODE

Member Student Table

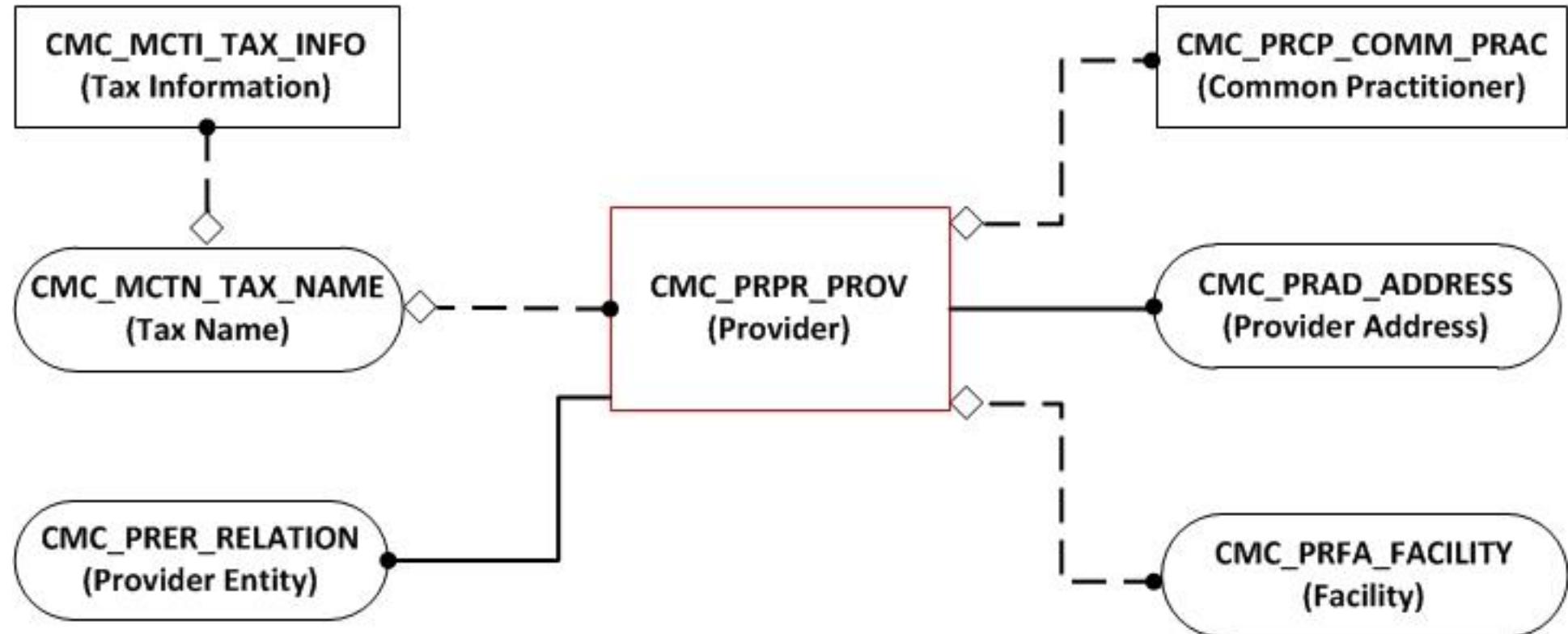
CMC_MEST_STUDENT	
	<u>MEME CK</u>
	<u>MEST EFF DT</u>
	MEST_TERM_DT
	MEST_MCTR_TRSN
	GRGR_CK
	MEST_SCHOOL_NAME
	MEST_TYPE
	MEST_LAST_VER_DT
	MEST_LAST_VER_NAME
	MEST_MCTR_VMTH

Provider – Data Model

Provider Data Model Structure



Provider Structure



Common Practitioner Table

CMC_PRCP_COMM_PRAC	
	<u>PRCP_ID</u>
	PRCP_SSN
	PRCP_LAST_NAME*
	PRCP_FIRST_NAME
	PRCP_MID_INIT
	PRCP_TITLE
	PRCP_SEX
	PRCP_BIRTH_DT
	PRCP_LAST_CHAN_DTM
	PRCP_TIER_NO
	PRCP_LAST_NAME_XLOW
	PRCP_MCCY_CTRY
	PRCR_ID*
	PRCP_MCTR_LANG
	PRCP_EXTN_ADDR_IND
	PRCP_NPI
	PRCP_TERM_DT

Provider Table

CMC_PRPR_PROV	
	PRPR ID
	PRPR_ENTITY*
	PRCR_ID*
	TPCT_MCTR_TCAT
	PRPR_PAY_CL METH*
	PRPR_MCTR_TYPE
	PRPR_MCTR_PRTY
	PRCF_MCTR_SPEC
	PRPR_NAME*
	PRPR_NPI
	PRCP_ID*
	PRAD_ID*
	PRAD_TYPE_CHECK*
	PRAD_TYPE_PRIM*
	MCTN_ID
	PRPR_STS
	PRPR_PREAUTH_IND
	PRPR_PAY_HOLD_DT
	PRPR_NAME_XLOW*
	PRPR_MCTR_VAL1

Provider Address Table

CMC_PRAD_ADDRESS	
	PRAD ID
	PRAD TYPE
	PRAD EFF DT
	PRAD_TERM_DT
	PRAD_ADDR1*
	PRAD_CITY*
	PRAD_STATE*
	PRAD_ZIP*
	PRAD_COUNTY
	PRAD_CTRY_CD
	PRAD_PHONE
	PRAD_FAX
	PRAD_EMAIL
	PRAD_PRACTICE_IND*
	PRAD_TYPE_MAIL*

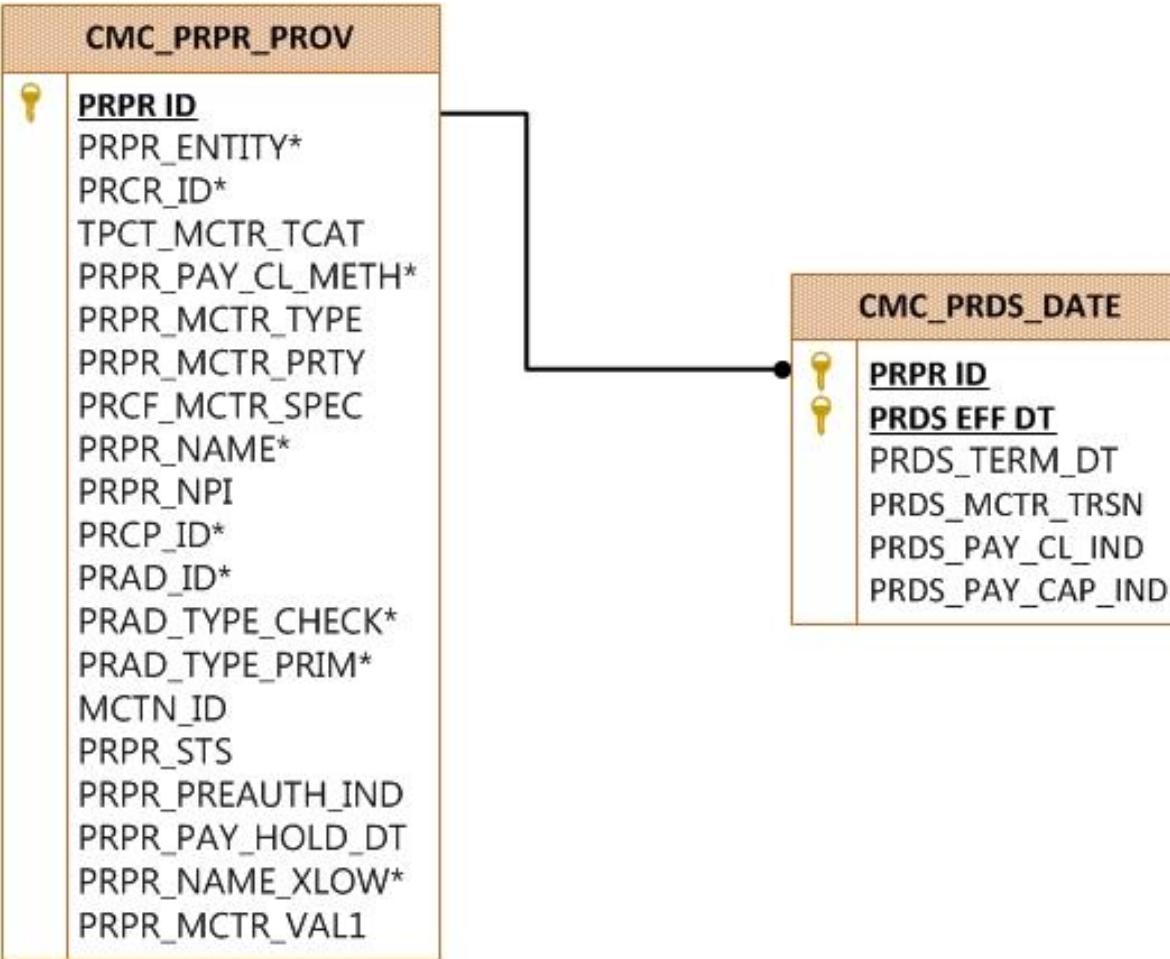
Provider Tax Name Table

CMC_MCTN_TAX_NAME	
	MCTN ID
	MCTN TYPE
	MCTN_NAME
	MCTN_LST_NAME
	MCTN_FIRST_NAME
	MCTN_STATUS
	MCTN_ADDR1
	MCTN_CITY
	MCTN_STATE
	MCTN_ZIP
	MCTN_COUNTY
	MCTN_PHONE
	MCTN_FAX
	MCTN_EMAIL

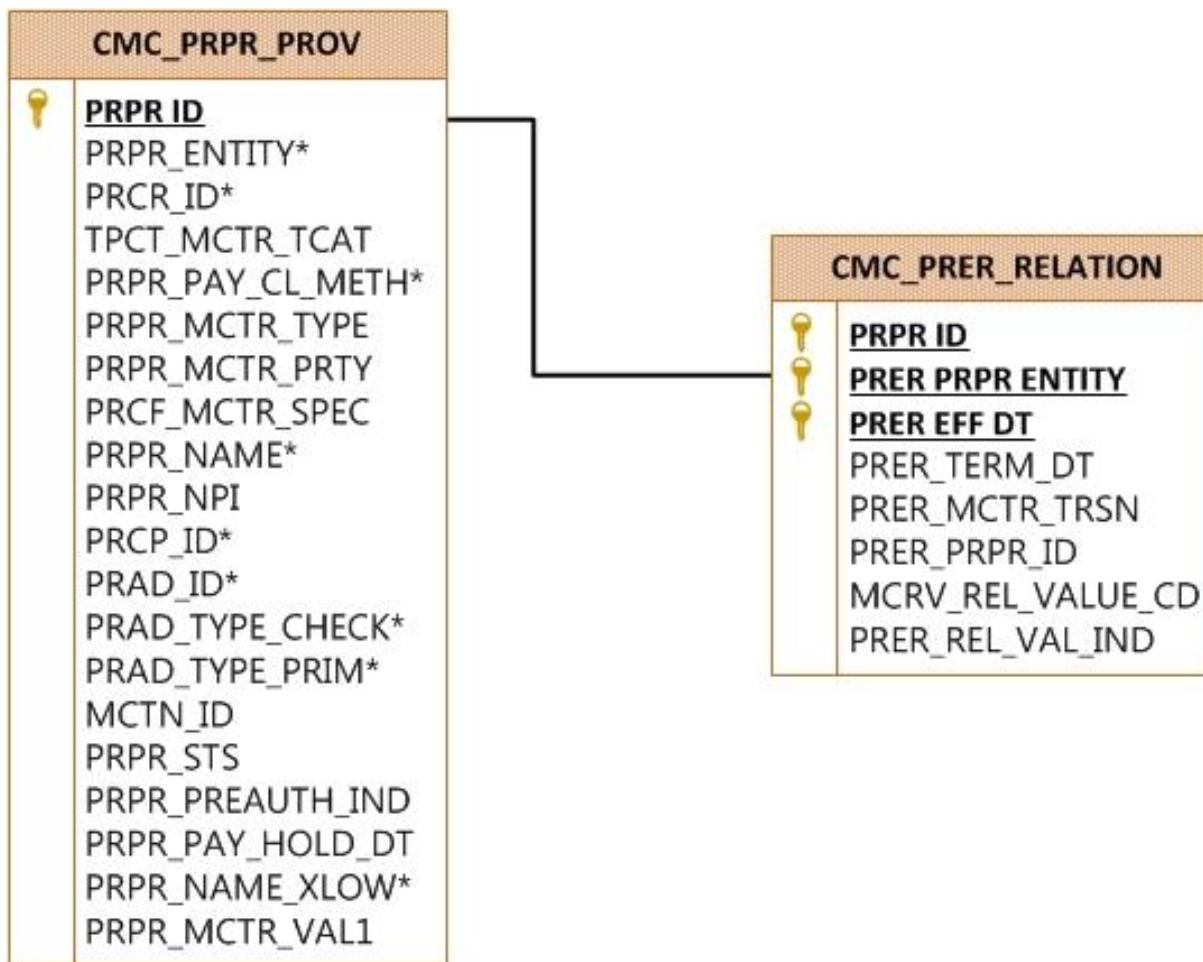
Provider Tax Information Table

CMC_MCTI_TAX_INFO	
	<u>MCTI ENTY ID</u>
	<u>MCTI TYPE</u>
	<u>MCTI EFF DT</u>
	MCTI_TERM_DT
	MCTI_MCTR_TRSN
	MCTN_ID
	MCTN_TYPE

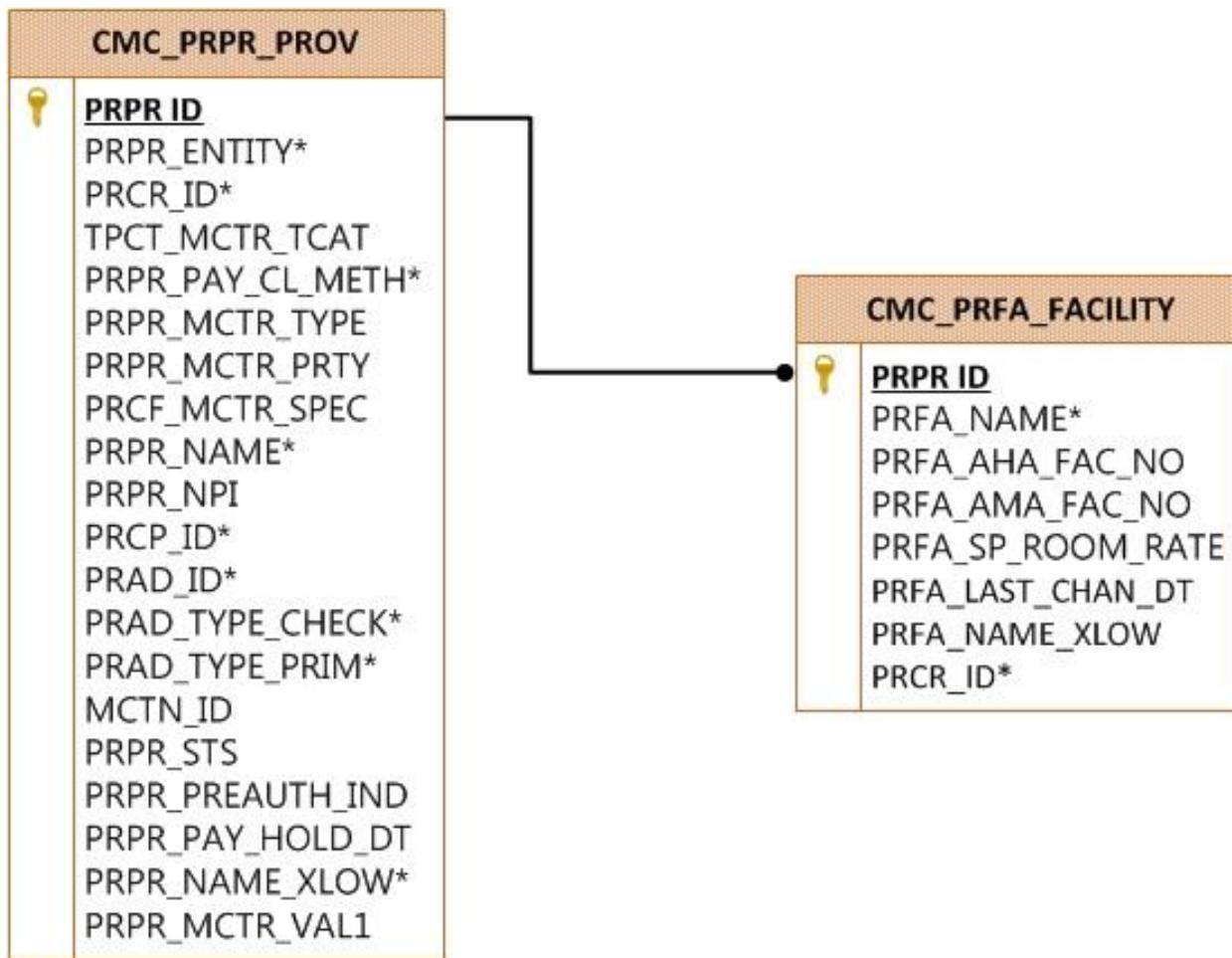
Provider Date Sensitivity Table



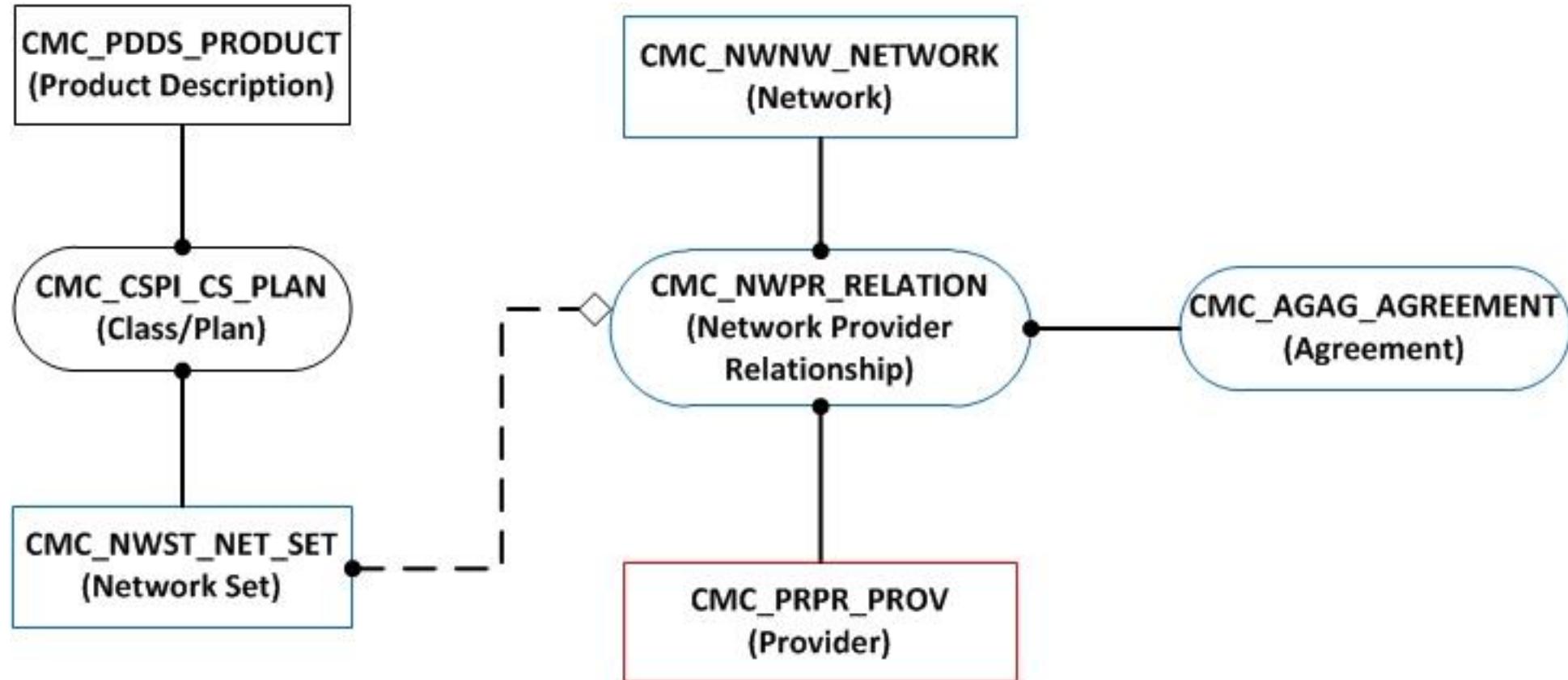
Provider Entity Relationship Table



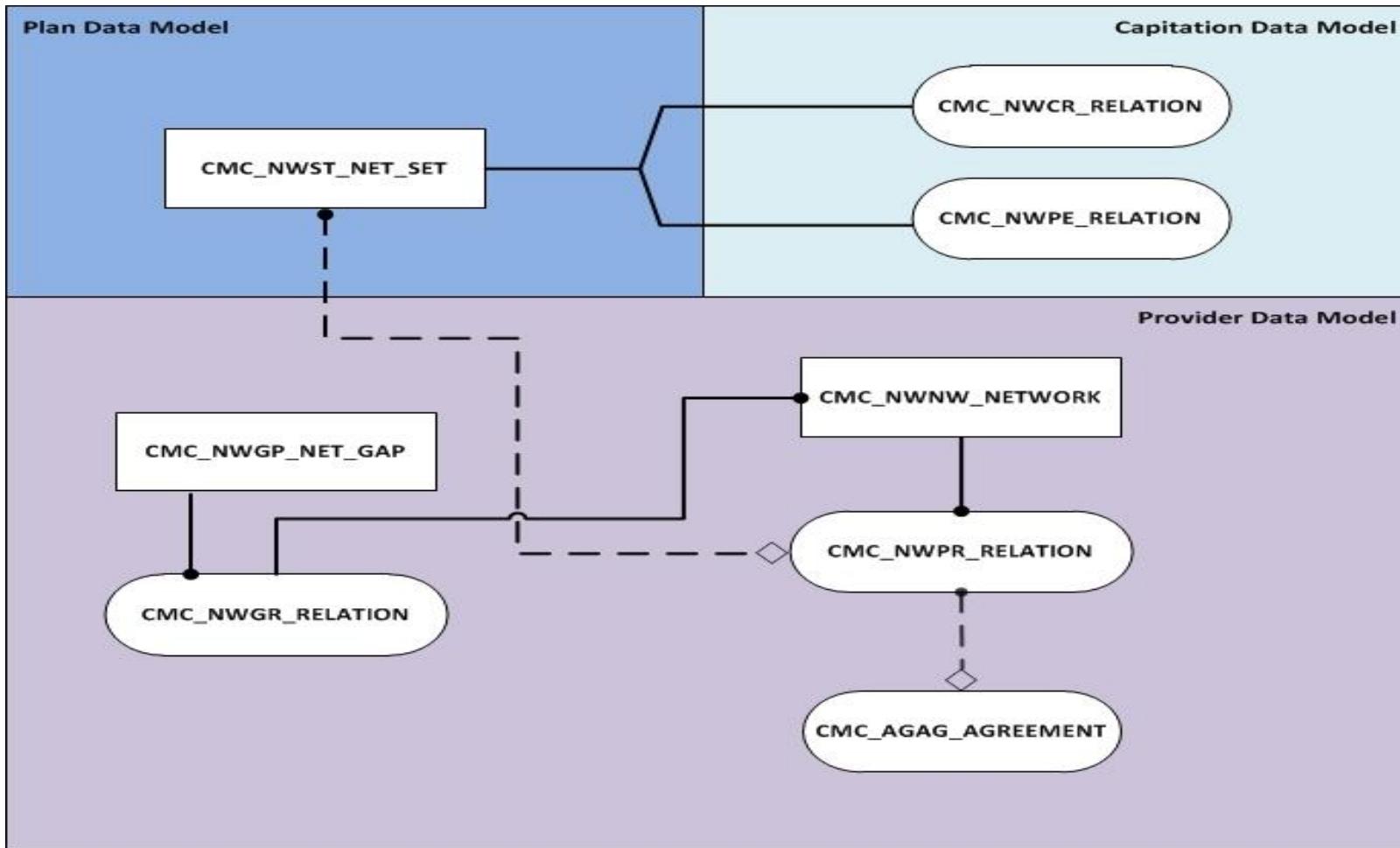
Facility Table



Provider Network Structure



Network Table Domains



Provider Network Relationship

NWPR
**(Network Provider
Relationship)**

CMC_NWPR_RELATION	
	PRPR_ID
	NWNW_ID
	NWPR_PFX
	NWPR_PCP_IND
	NWPR_EFF_DT

NWPE
**(Network PCP Cap
Relationship)**

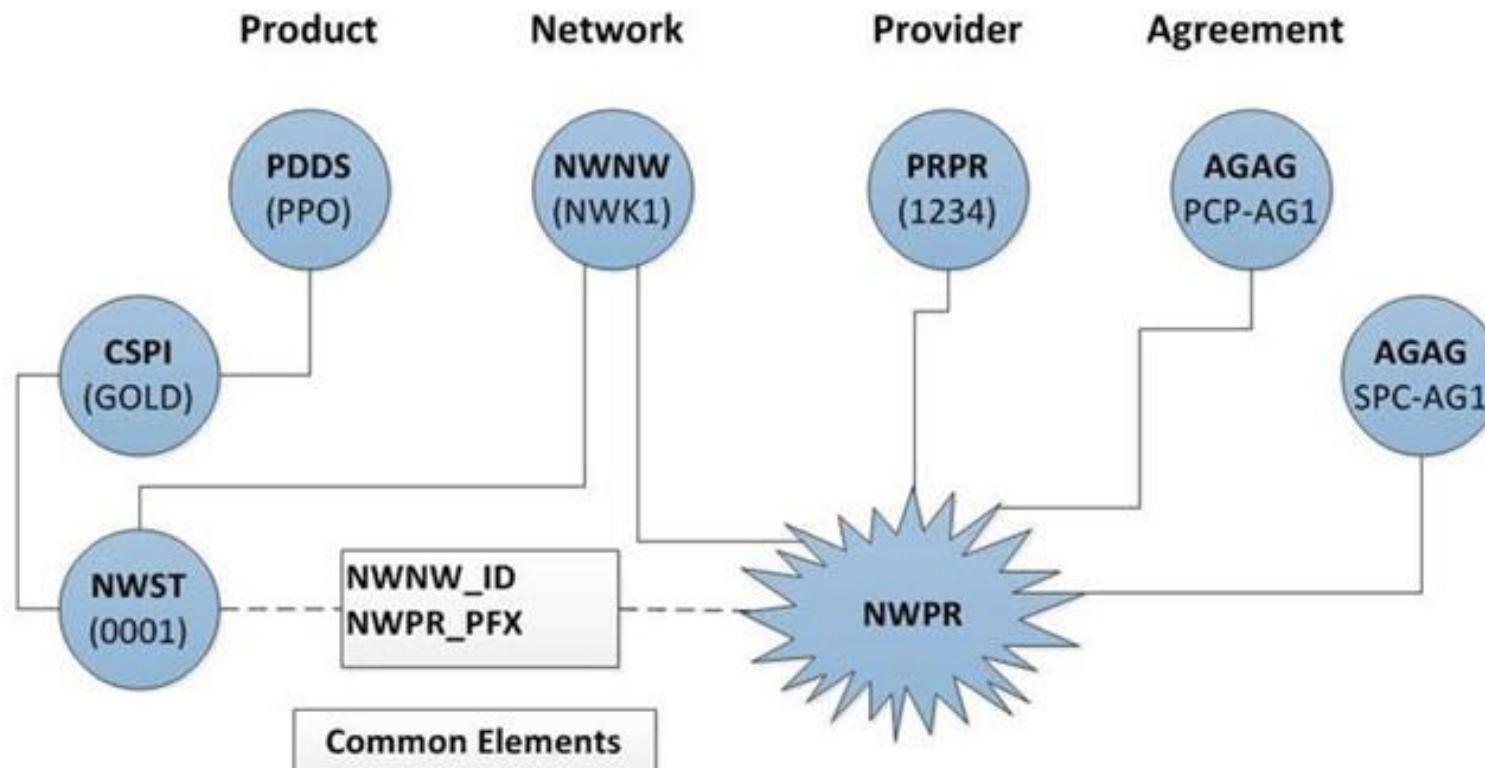
CMC_NWPE_RELATION	
	PRPR_ID
	NWNW_ID
	NWPE_PFX
	NWPE_CR_PR_ID
	NWPE_EFF_DT

NWCR
**(Network Capitation
Relationship)**

CMC_NWCR_RELATION	
	NWNW_ID
	NWCR_PFX
	NWCR_CR_PR_ID
	NWCR_EFF_DT

Provider Network Relationship Contd..

Network Provider Relationship



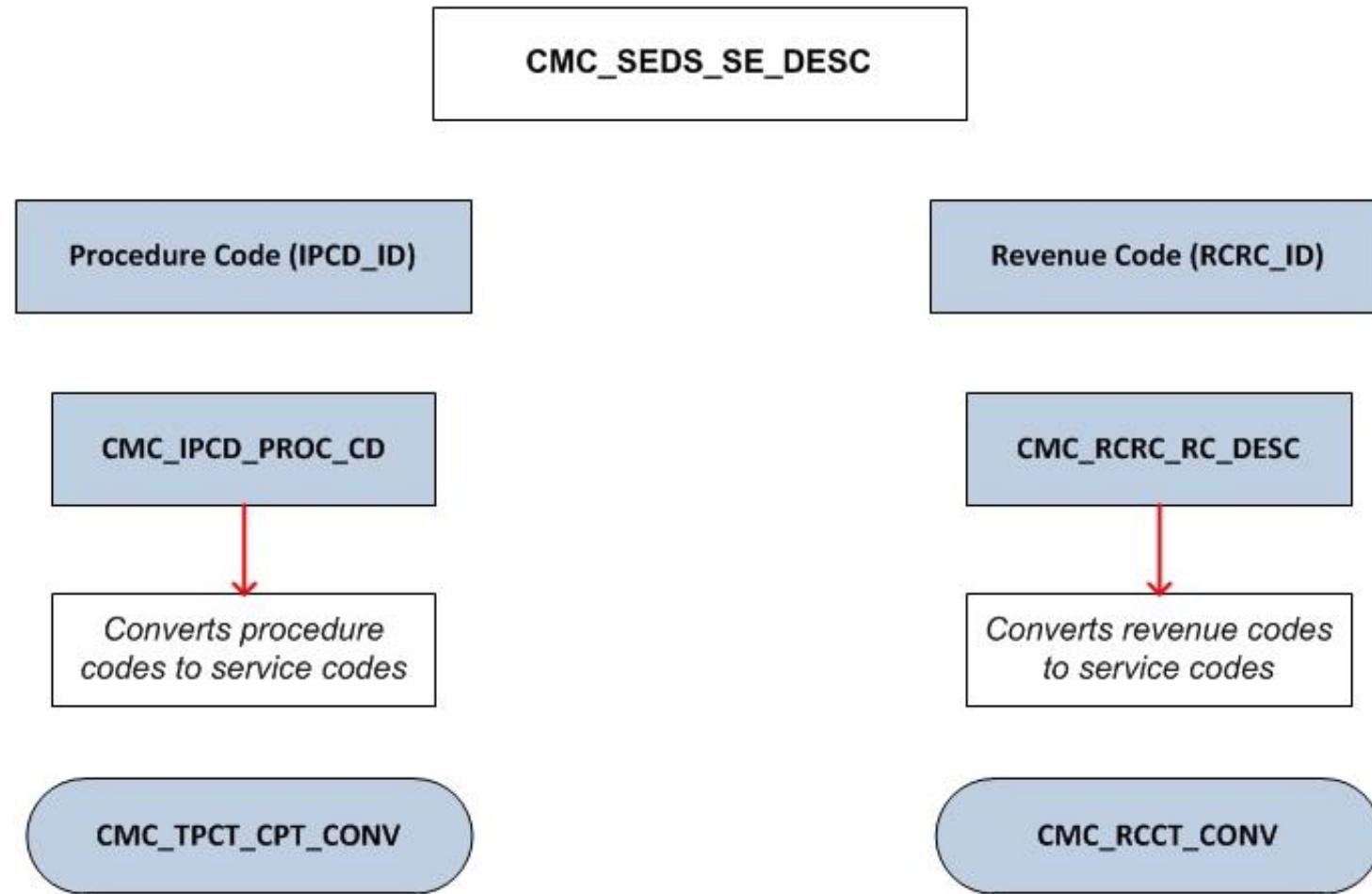
Agreement Table

CMC_AGAG AGREEMENT	
	<u>AGAG ID</u>
	<u>AGAG EFF DT</u>
	AGAG_TERM_DT
	AGAG_CAT
	AGAG_MCTR_TYPE
	AGAG_CL_ACPT_MTHS
	AGAG_IP_PRICE_IND
	AGAG_OP_PRICE_IND
	AGAG_OP_MULT_PCT
	AGAG_OI_IND
	AGSE_PFX
	PFPF_ID
	AGAG_PF_IND
	AGAG_NWX_PROF_IND
	AGAG_DESC

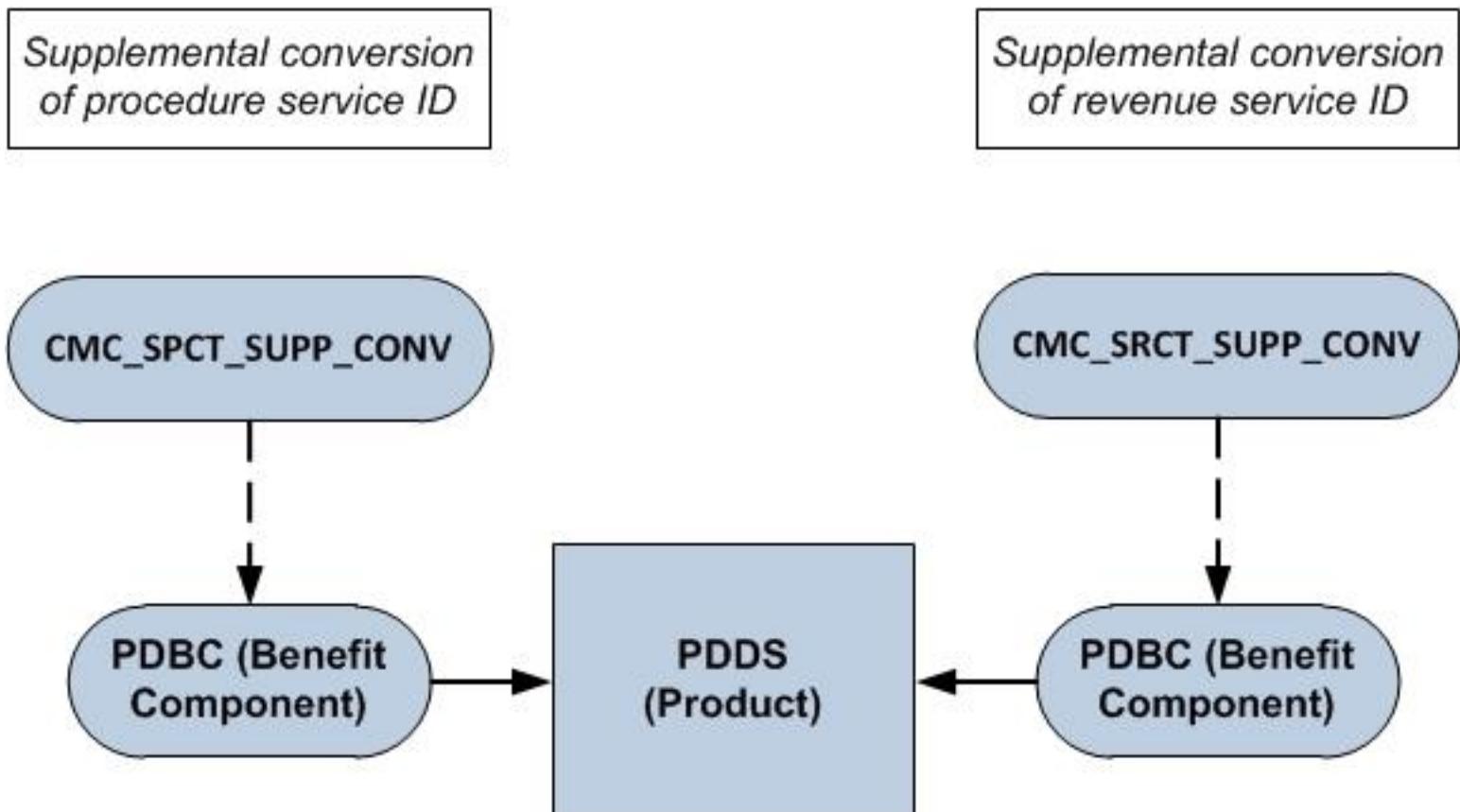
Claims and Accounting

– Data Model

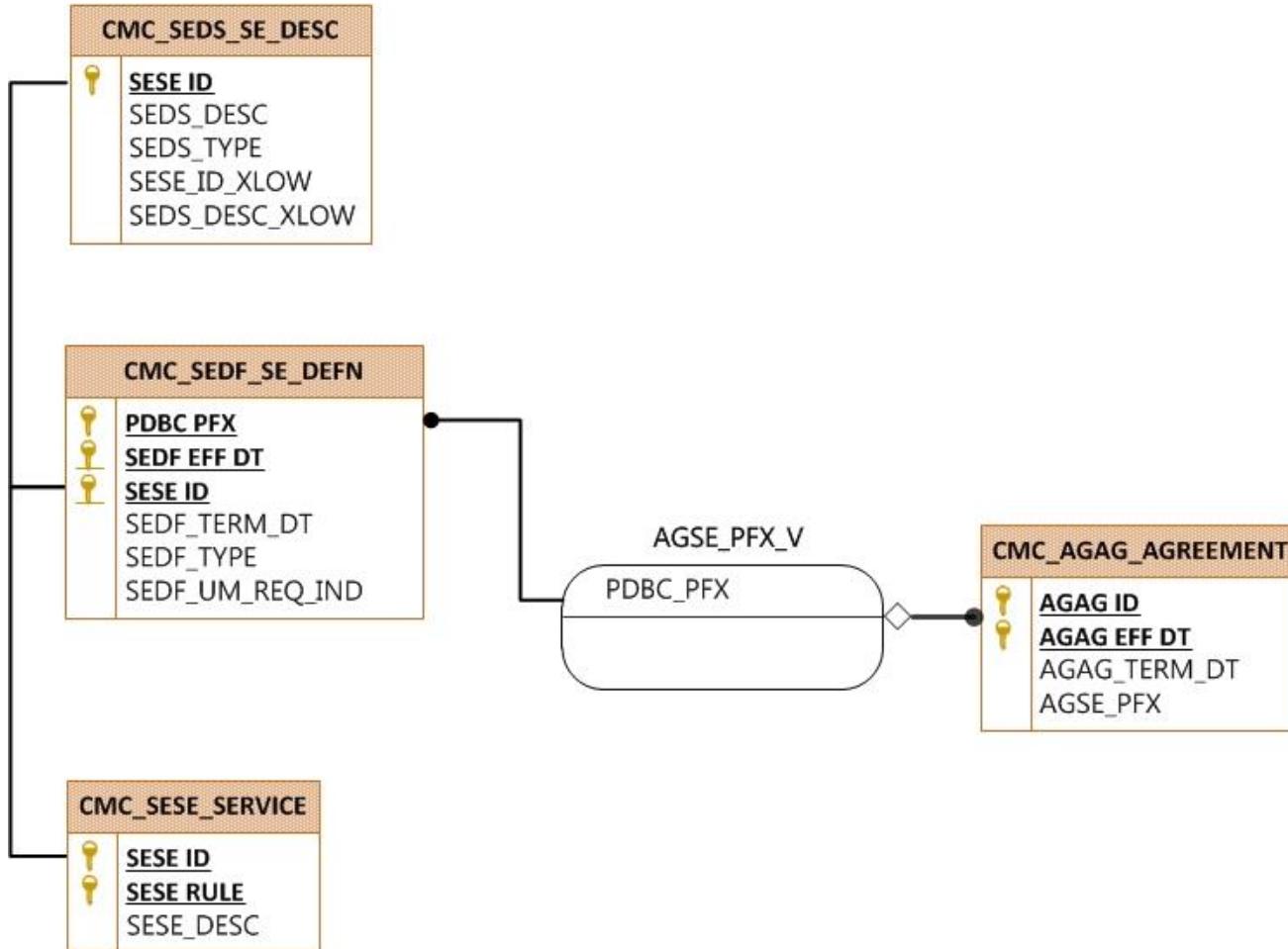
Service Conversion Process



Service Conversion Process Contd..



Pricing

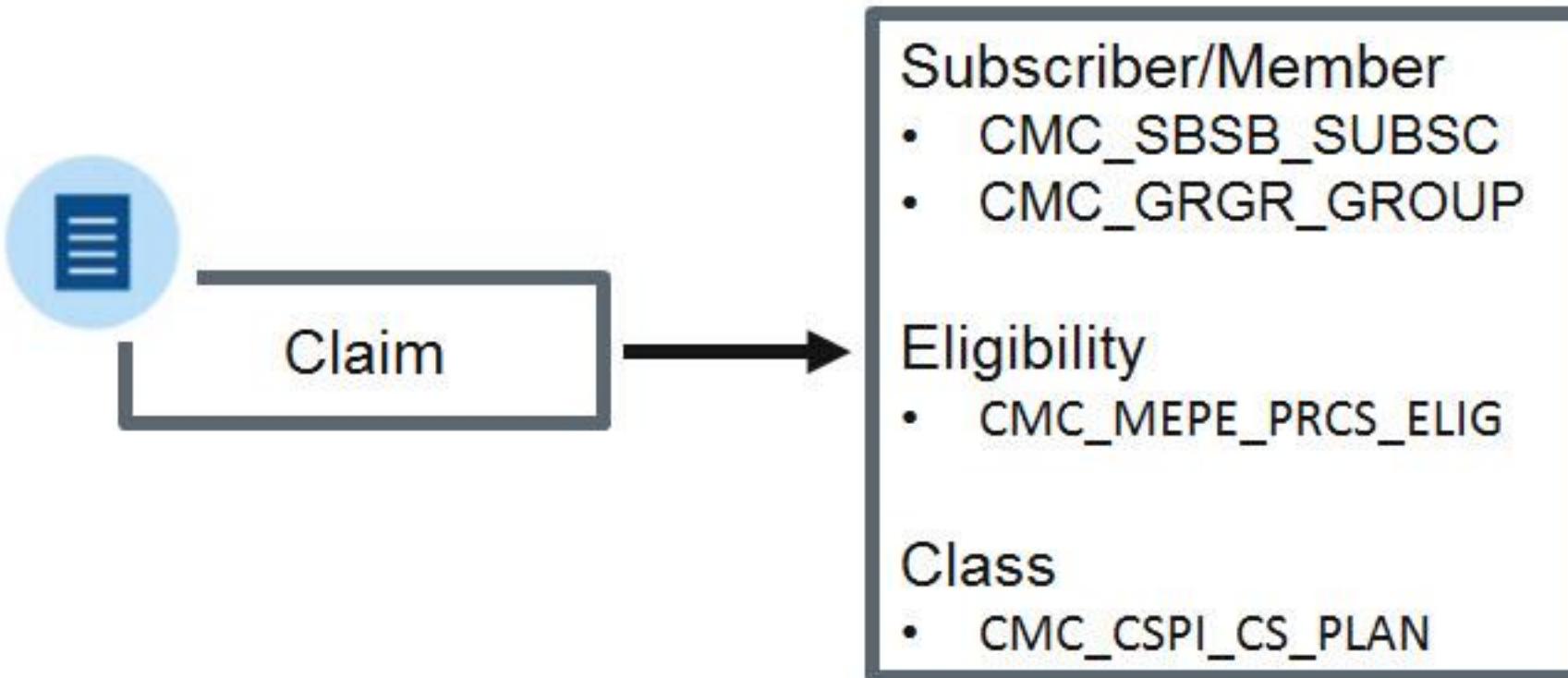


NetworX Tables

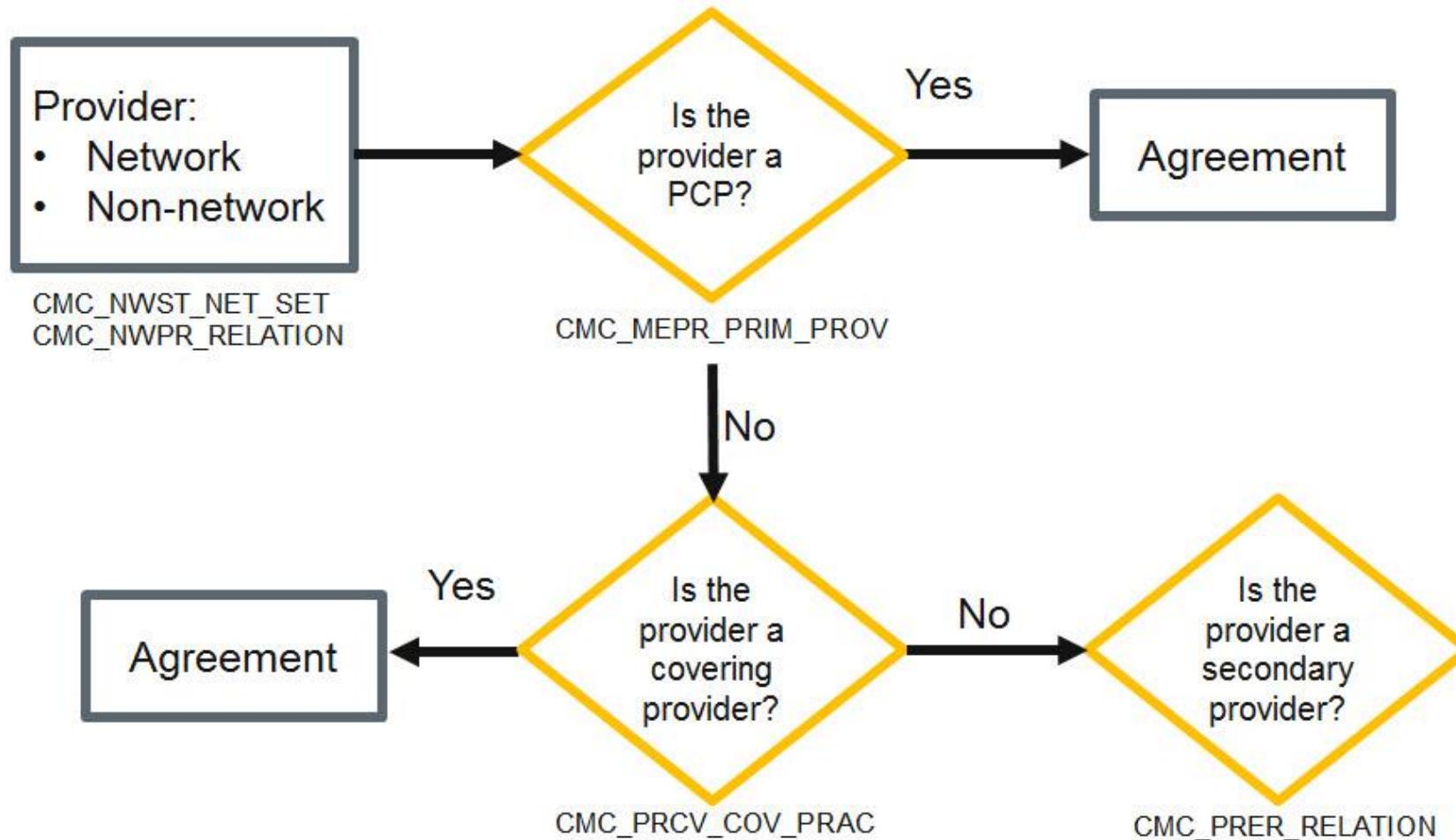
Integrated Pricer NetworX Tables:

- NWX_NSRS_RATE_SHT
- NWX_NRST_RS_TERMS
- NWX_NSHC_SCHEDULES
- NWX_NCGP_CD_GROUP
 - NWX_NQBN_QUAL_BEAN
 - NWX_NCGV_CD_VALUE

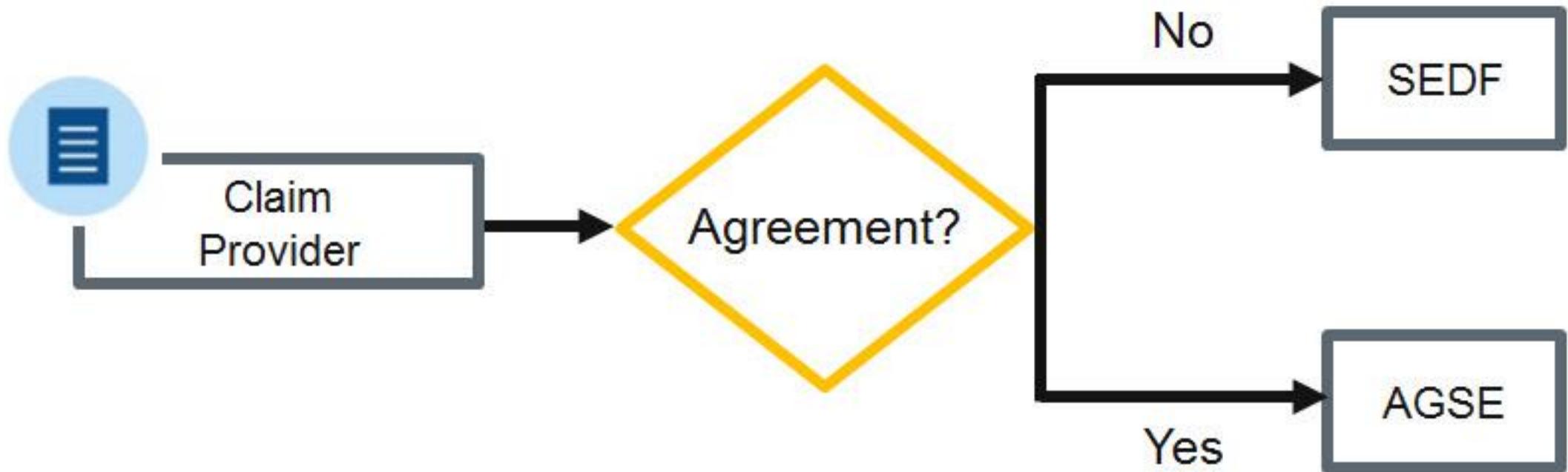
Claim Adjudication Process Step One



Claim Adjudication Process Step Two



Claim Adjudication Process Step Three



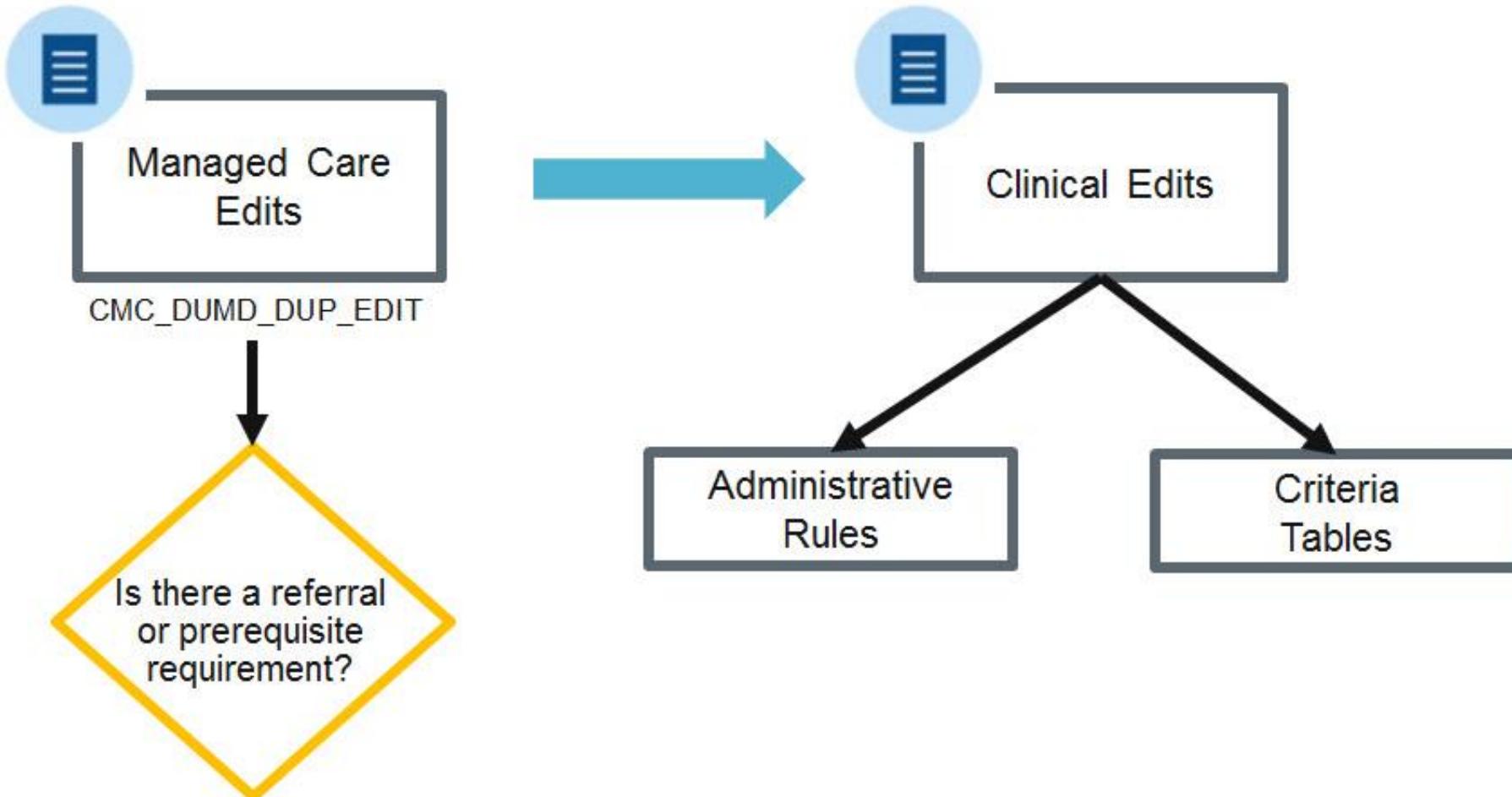
Claim Adjudication Process Steps Four and Five

Step four is charge roll ups:

- All-inclusive per diem
- All-inclusive per case
- DRG pricing types

Step five is duplicate editing and claims history check.

Claim Adjudication Process Steps Six and Seven

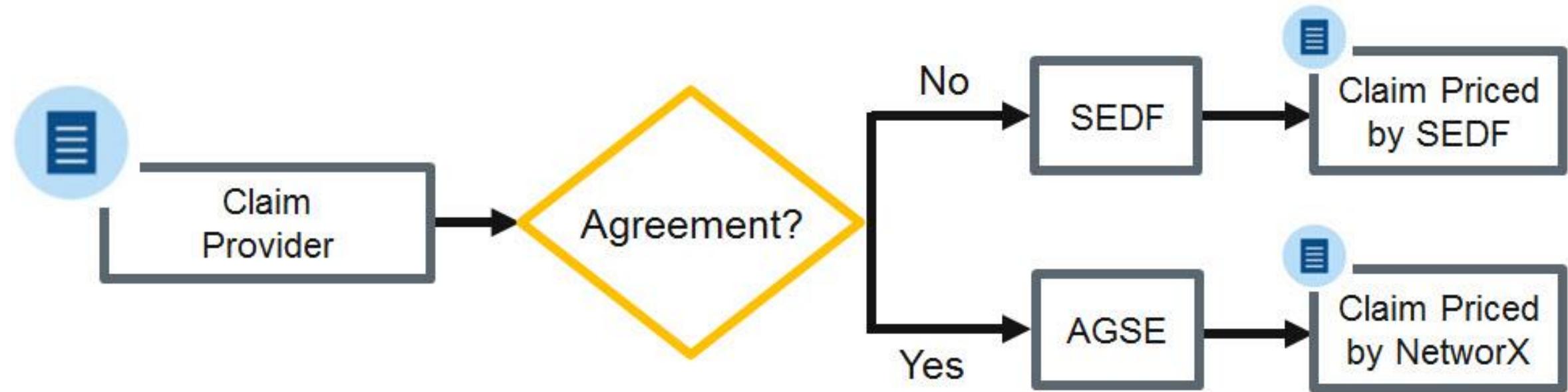


Claim Adjudication Process Step Eight

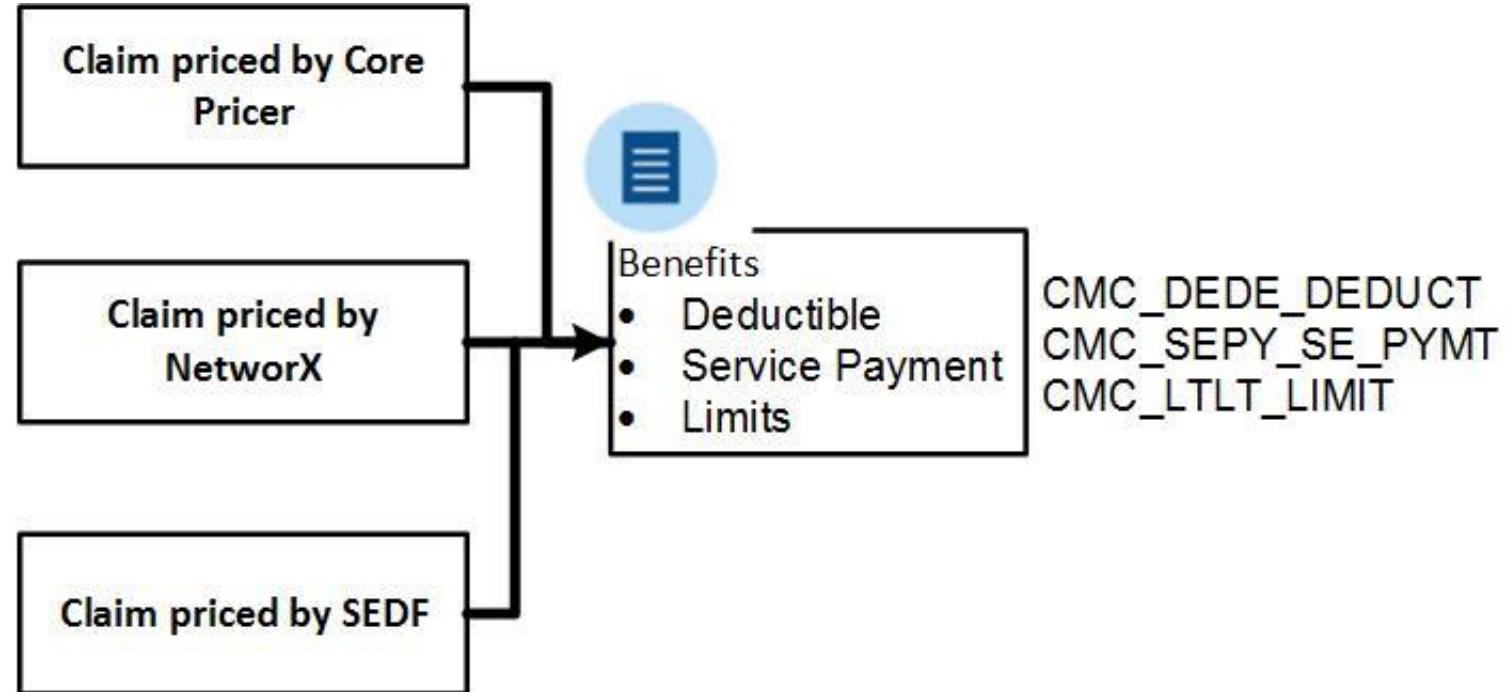
In step eight, line item prefixes populate:

- CMC_CDML_CL_LINE
- CMC_CDDL_CL_LINE

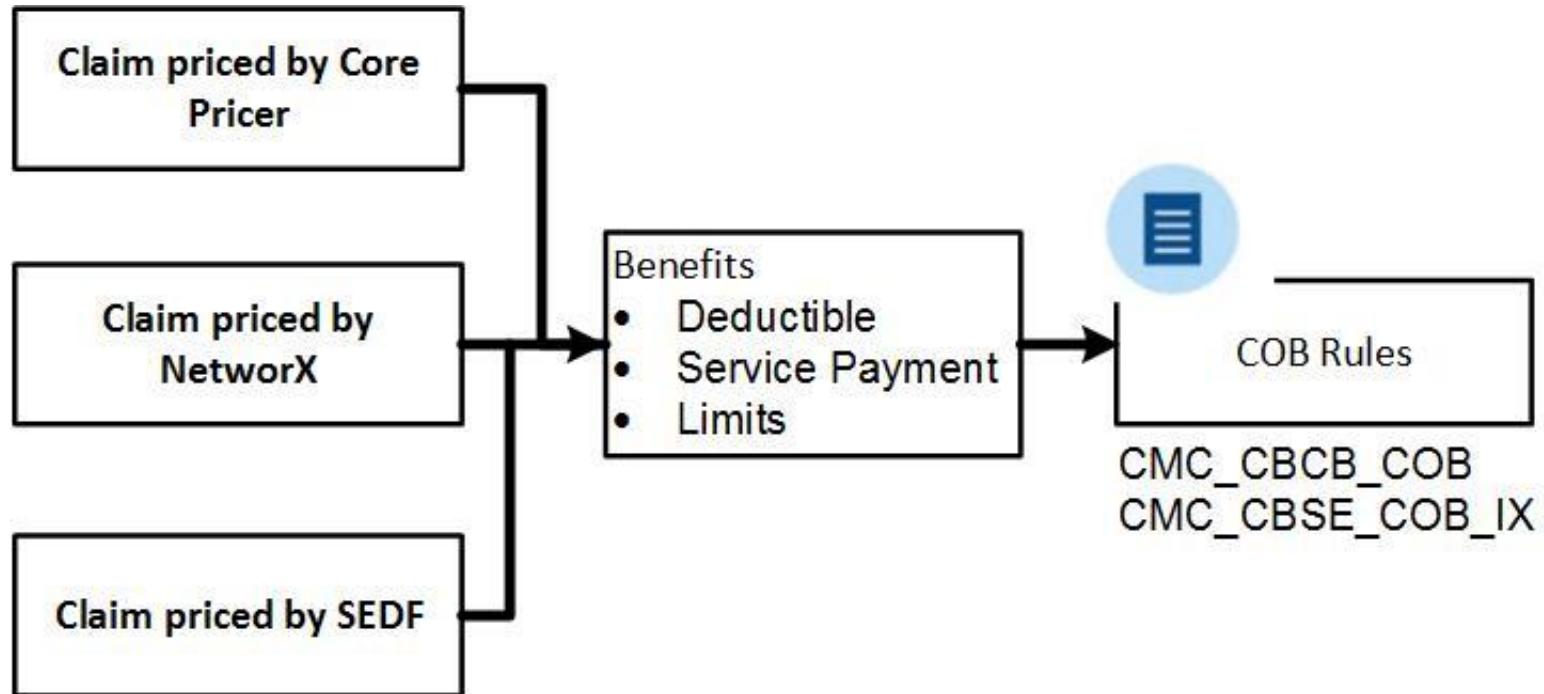
Claim Adjudication Process Step Nine



Claim Adjudication Process Step 10



Claim Adjudication Process Step 11



Claim Adjudication Process Steps 12 and 13

In step 12, there is payment drag:

- CMC_AIAI_ADMIN_INFO
- CMC_AGAG AGREEMENT

In step 13, update accumulators:

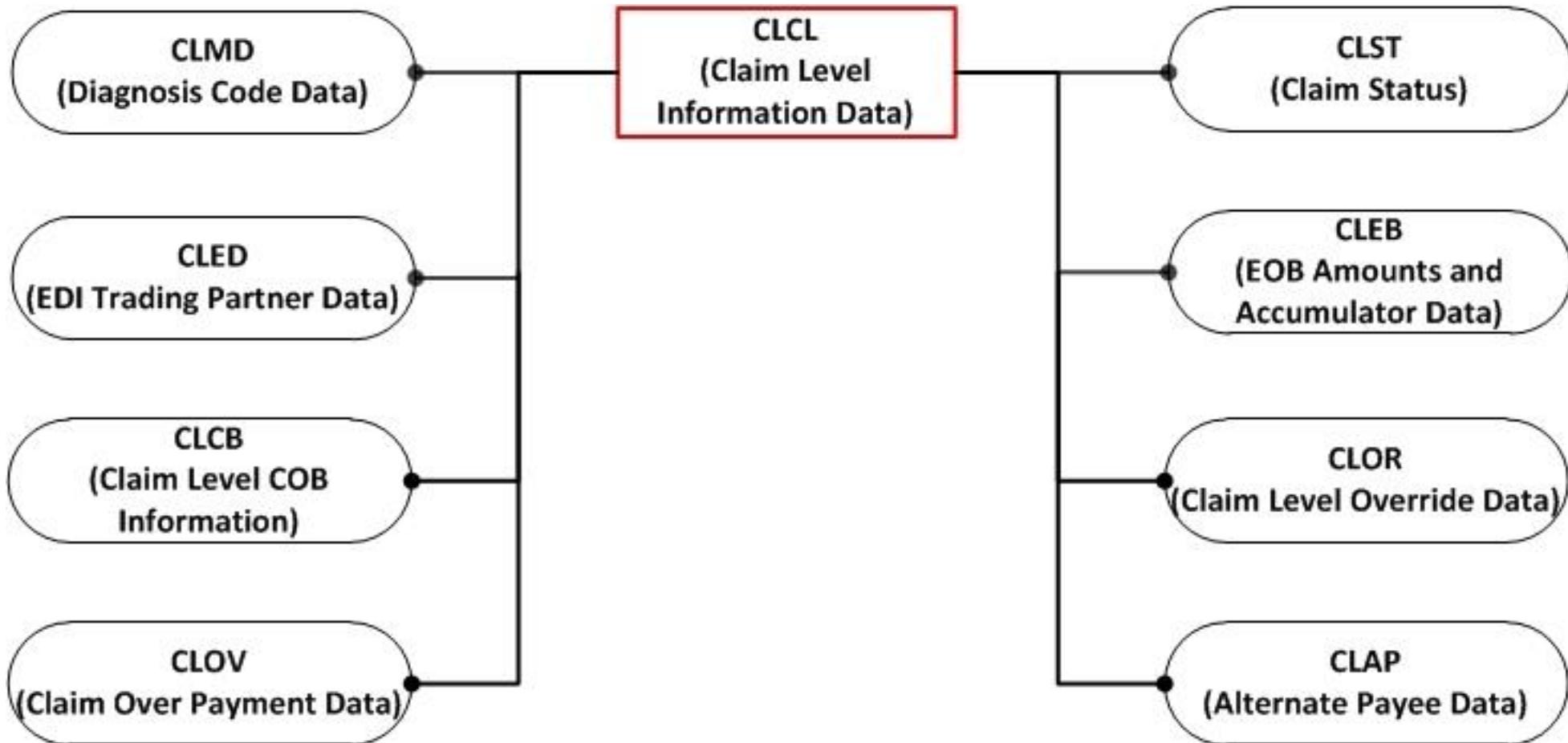
- CMC_EBCL_EOB_DATE
- CMC_MATX_ACCUM_TXN
- CMC_FATX_ACCUM_TXN

Claim Adjudication Process Step 14

Update claim status:

- 01 - Claim awaiting batch
- 15 - Claim pends with error

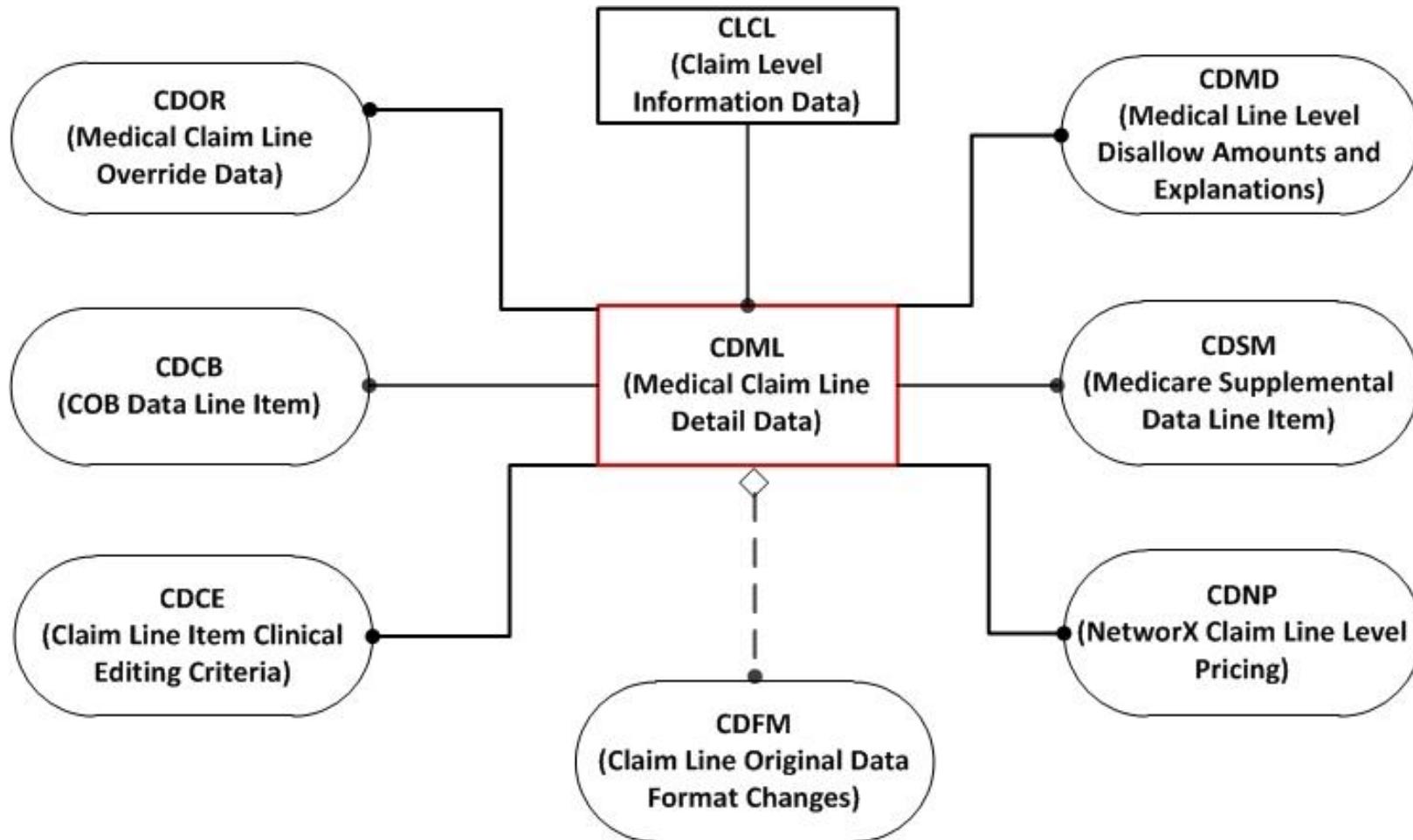
Claims Tables



Claim Summary Table

CMC_CLCL CLAIM	
!	CLCL_ID
	MEME_CK*
	GRGR_CK*
	SBSB_CK*
	SGSG_CK*
	PRPR_ID*
	CLCL_CL_TYPE*
	CLCL_CL_SUB_TYPE*
	CLCL_CUR_STS*
	CLCL_SITE*
	CLCL_LAST_ACT_DTM*
	CLCL_INPUT_DT*
	CLCL_RECV_DT*
	CLCL_ACPT_DTM*
	CLCL_LOW_SVC_DT*
	CLCL_HIGH_SVC_DT*
	CSPD_CAT*
	CSCS_ID*
	CSPI_ID*
	PDPP_ID*
	MEPE_FI*
	MEPE_PLAN_ENTRY_DT*
	CLCL_COBRA_IND*
	CLCL_ME_AGE*
	MEME_REL*
	MEME_SEX*
	MEME_RECORD_NO*
	PDBC_PFX_SEDF*

Claim Line Item Detail Data



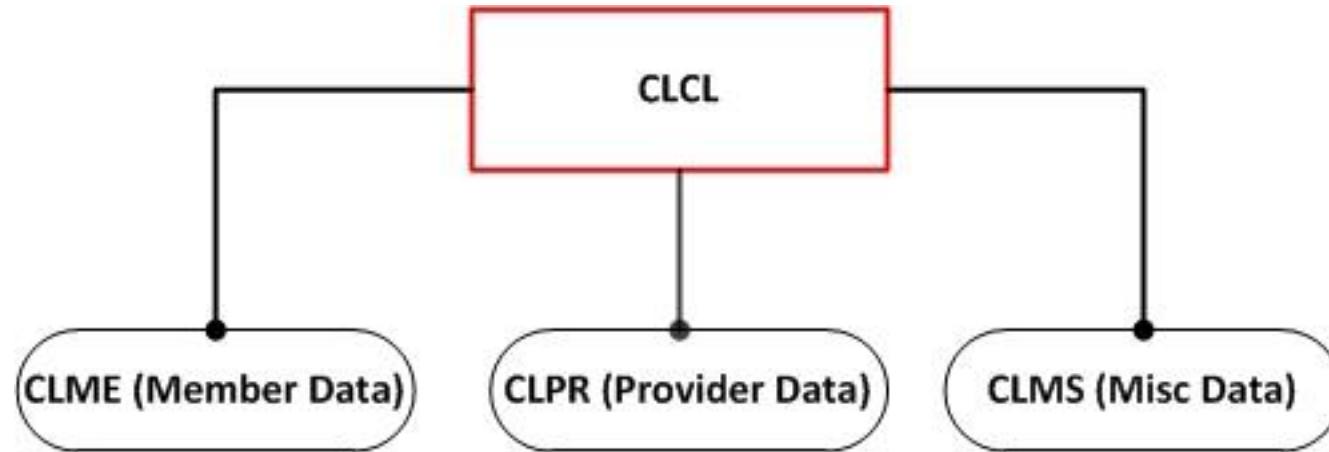
Claim Line Item Details Table

CMC_CDML_CL_LINE	
CLCL_ID	
CDML_SEQ_NO	
MEME_CK*	
PRPR_ID*	
LOBD_ID*	
PDVC_LOBD_PTR*	
CDML_CUR_STS*	
SEPC_PRICE_ID*	
SESE_ID*	
SESE_RULE*	
PSCD_ID*	
IDCD_ID*	
IDCD_ID_REL*	
CDML_FROM_DT*	
CDML_TO_DT*	
CDML_CHG_AMT*	
CDML_CONSIDER_CHG*	
CDML_ALLOW*	
CDML_UNITS_ALLOW*	
CDML_DED_AMT*	
CDML_COPAY_AMT*	
CDML_COINS_AMT*	
CDML_AG_PRICE*	
CDML_CL_NTWK_IND*	

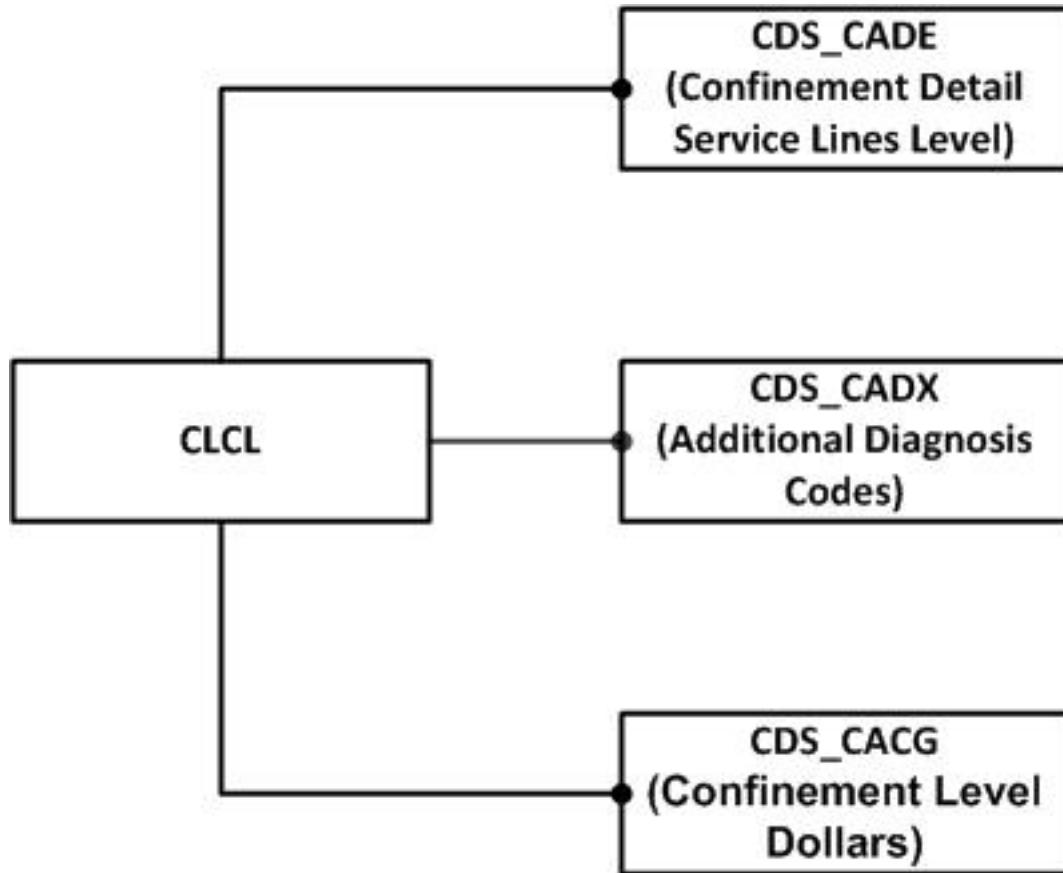
Medical Claim Diagnosis Table

CMC_CLMD_DIAG	
CLCL ID	
CLMD TYPE	
MEME_CK*	
IDCD_ID	
CLMD_POA_IND	
IDCD_ID_SUB*	
IDCD_ID_TRANS	

XC Electronic Adjudication



Inpatient Confinement Reporting



Claim Underpayment

CLCL

<u>Claim Id</u>	<u>Status</u>	<u>Paid Amt</u>	<u>Claim ID Adjusted To / From</u>
111111111100	01, 02, 91	\$50	To: 111111111101
111111111101	01, 02	\$100	From: 111111111100

CDML

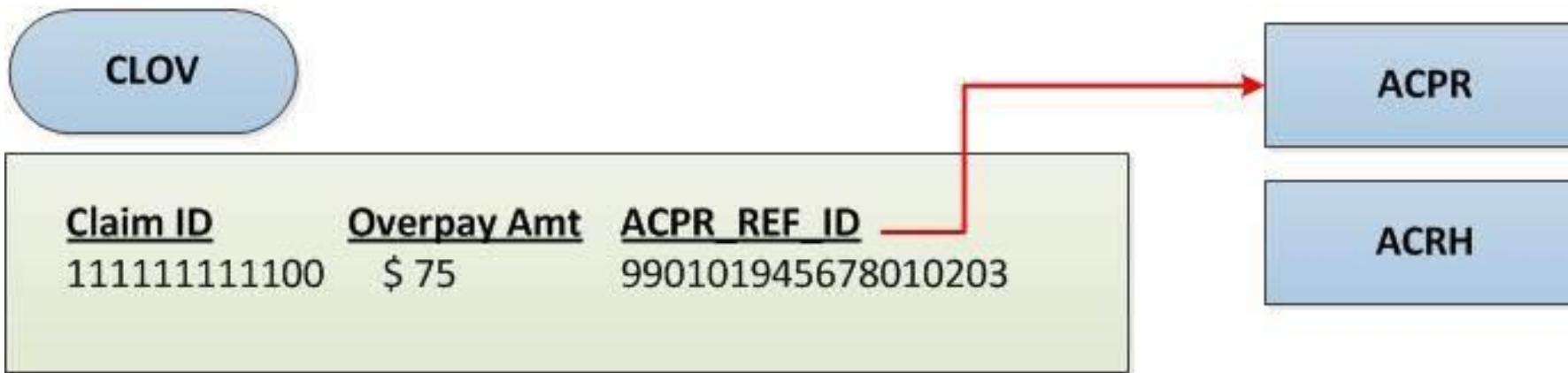
<u>Claim Id</u>	<u>Line</u>	<u>Status</u>	<u>Paid Amt</u>
111111111100	1	01, 02, 91	\$25
111111111100	2	01, 02, 91	\$25
<hr/>			
111111111101	1	01, 02	\$75
111111111101	2	01, 02	\$25

CLST

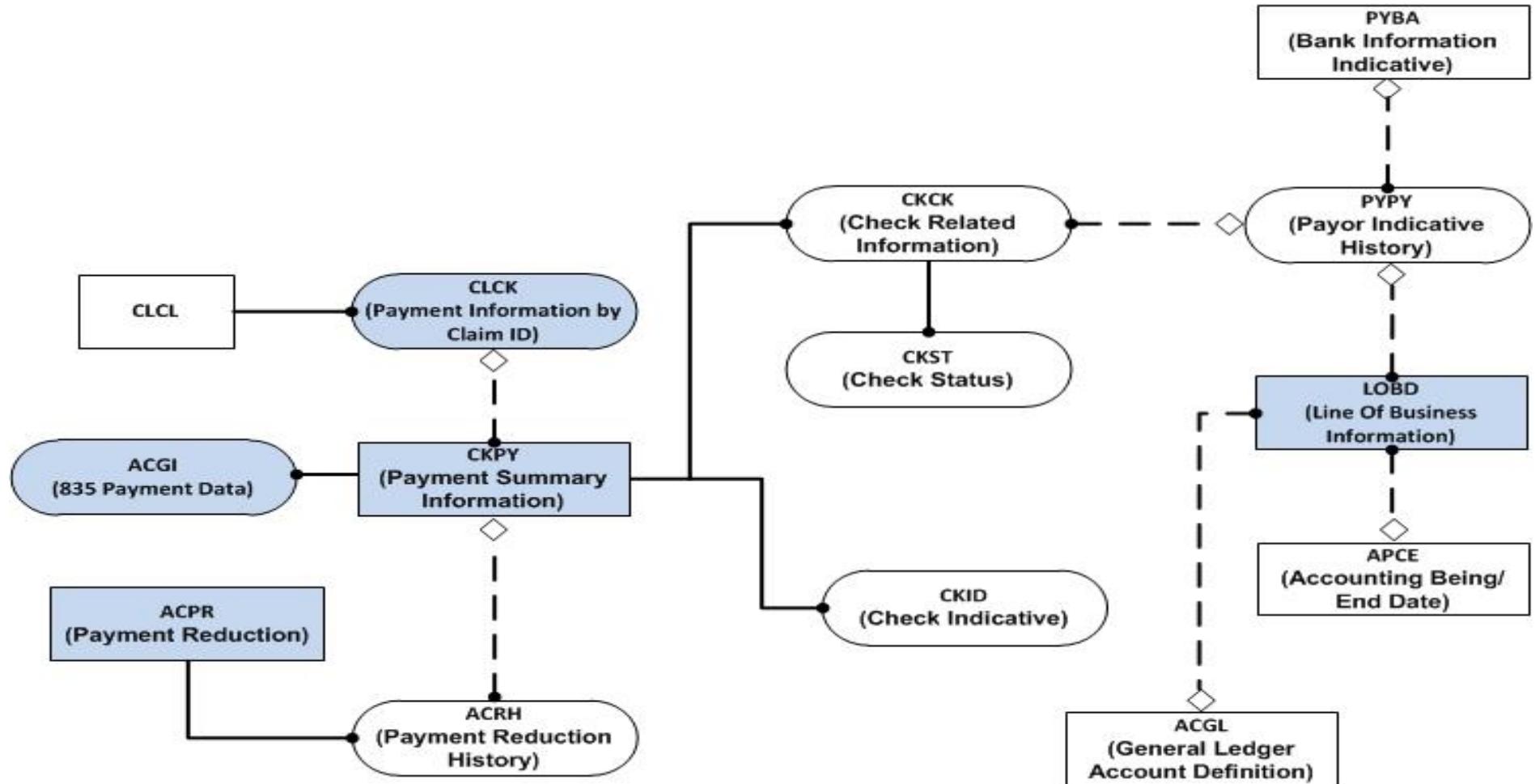
<u>Claim Id</u>	<u>Status</u>
111111111100	01
111111111100	02
111111111100	91
<hr/>	
111111111101	01
111111111101	02

Claim Overpayment

CLCL				
<u>Claim ID</u>	<u>Status</u>	<u>Paid Amt</u>	<u>Claim ID Adj To / From</u>	
111111111100	01, 02, 91	\$100	To: 111111111101	
111111111101	01, 02	\$25		From: 111111111100



Accounting Tables



Line of Business Table

CMC_LOBD_LINE_BUS	
	 LOBD_ID
	LOBD_NAME*
	LOBD_ADDR1*
	LOBD_CITY*
	LOBD_STATE*
	LOBD_ZIP*
	LOBD_COUNTY
	LOBD_PHONE
	LOBD_FAX
	LOBD_EMAIL
	LOBD_PAY_CL_METH*
	LOBD_EOB_COPY_IND
	PYPY_ID*
	LOBD_ID_COMM*
	LOBD_CR_RED_IND
	LOBD_PR_RED_IND

Payment Information by Claim ID Table

CMC_CLK_CLM_CHECK	
	<u>CLCL ID</u>
	<u>CLK PAYEE IND</u>
	<u>LOBD ID</u>
	CKPY_REF_ID*
	CKPY_PAY_DT*
	PRPR_ID*
	MEME_CK*
	SBSB_CK*
	CLK_PAYEE_PR_ID
	CLK_COMB_IND*
	CLK_ORIG_AMT*
	CLK_EOB_IND
	CLK_NTWK_IND
	CLK_NET_AMT*
	CLCL_CL_TYPE*

Payment Summary Info Table

CMC_CKPY_PAYEE_SUM	
	<u>CKPY REF ID</u>
	CKPY_TYPE*
	CKPY_PAY_DT*
	LOBD_ID*
	CKPY_PAYEE_PR_ID
	CKPY_PAYEE_CK
	CKPY_PAYEE_TYPE*
	CKPY_PYMT_TYPE*
	CKPY_COMB_IND*
	CKPY_PER_END_DT*
	CKPY_ORIG_AMT*
	CKPY_DEDUCT_AMT*
	CKPY_NET_AMT*
	CKPY_CURR_CKCK_SEQ

Payment Reduction Table

CMC_ACPR_PYMT_RED	
	<u>ACPR REF ID</u>
	<u>ACPR SUB TYPE</u>
	ACPR_TX_YR*
	ACPR_TYPE*
	ACPR_CREATE_DT*
	LOBD_ID*
	ACPR_PAYEE_PR_ID
	ACPR_PAYEE_CK
	ACPR_PAYEE_TYPE*
	ACPR_AUTO_REDUC*
	ACPR_ORIG_AMT*
	ACPR_RECov_AMT
	ACPR_ReCD_AMT
	ACPR_NET_AMT*
	ACPR_STS*
	EXCD_ID

Batch Print Tables

CMC_BPID_IND	
	<u>SYIN INST</u>
	<u>BPID STOCK ID</u>
	<u>BPID TYPE</u>
	<u>BPID SEQ NO</u>
	BPID_STOCK_ID*
	CKPY_REF_ID*
	CKPY_PAYEE_CK*
	CKPY_PAY_DT*
	LOBD_ID*
	LOBD_NAME*
	PYPY_ID*
	PYBA_ID*
	CKPY_PAYEE_TYPE*
	CKCK_PAYEE_NAME*
	CKPY_NET_AMT*
	BPID_PRINTED_DT*
	SYIN_REF_ID*

Lesson Objectives

You are now able to successfully describe:

- Facets Data Model
- Data Types
- Database Terms and Common Columns
- Tables and Keys
- Facets Naming Convention
- Data Dictionary
- Group, Class, Plan, Product – Data Model
- Plan – Data Model
- Subscriber Member – Data Model
- Provider – Data Model
- Claims and Accounting – Data Model

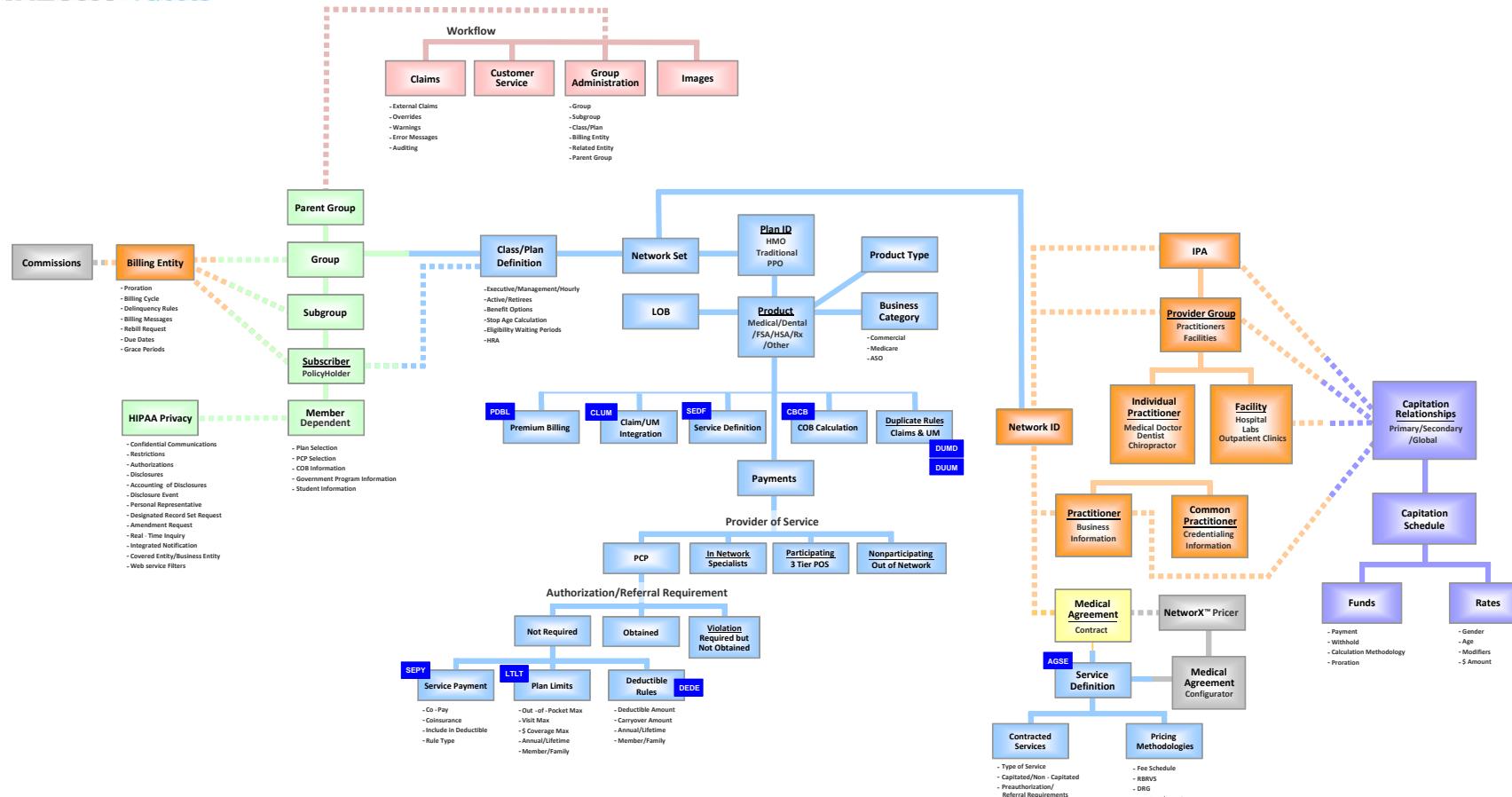
Questions??



Thank you!!

Facets Flowchart Handout

TriZetto® Facets®





Facets Solution Overview

Learning Services

Lesson Objectives

Upon completion of this session, you will be able to:

- Benefits
- Required system architecture
- Features and functions
- Roles of users
- Necessary support roles



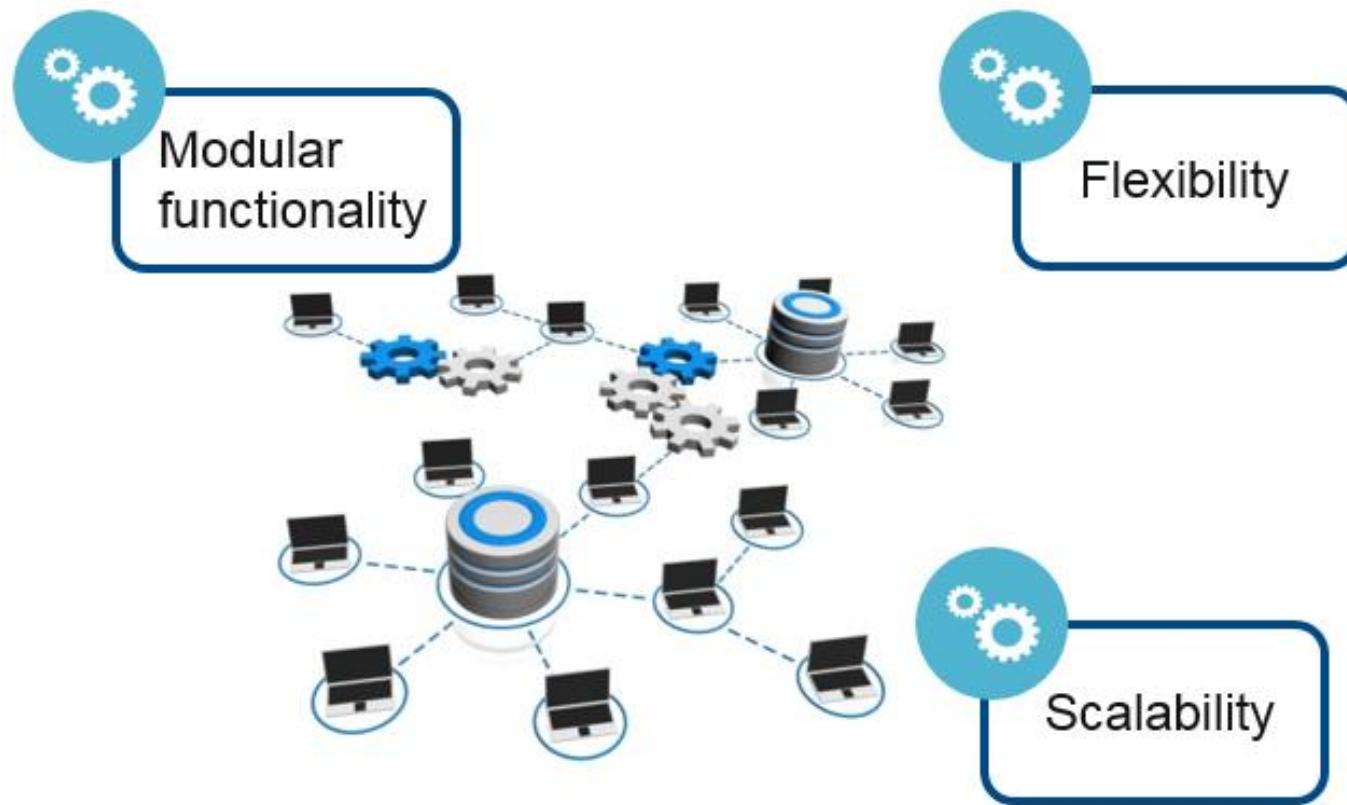
Facets Solution Overview

Benefits

Facets

-  **Enterprise-Wide Integrated Platform**
-  **Broad & Deep Functionality**
-  **Flexible & Open Architecture**
-  **Demonstrated Scalability**
-  **Automation & Configurability**
-  **Proven Track Record**

Enterprise-Wide Integrated Platform



Broad and Deep Functionality

Broad and deep functionality integrates:

- Consumer
- Care Management
- Medicare & Specialty functionality



Flexible and Open Architecture

Flexible and open architecture features:

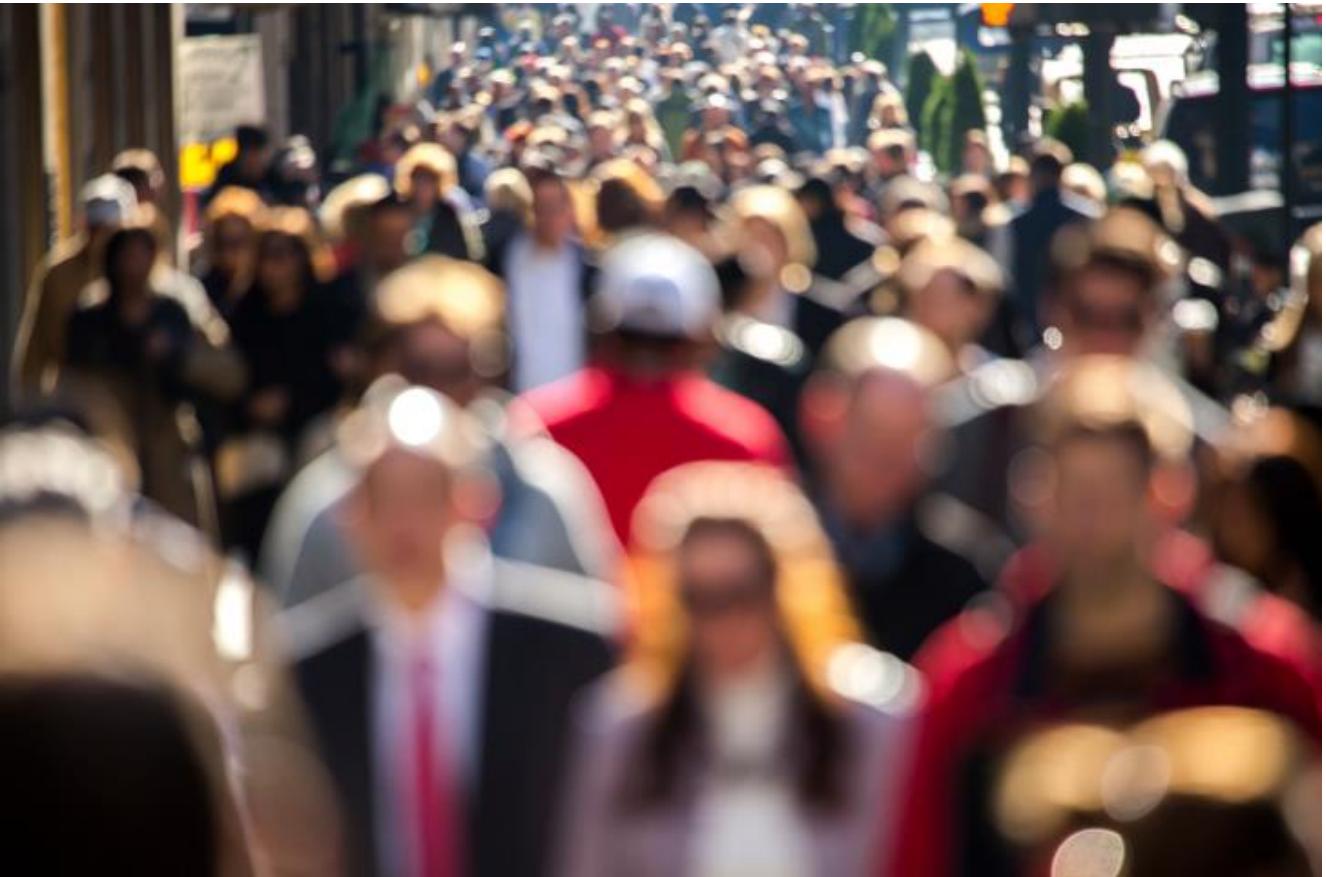
- Highly adaptable service-oriented architecture
- Maximum technology choices



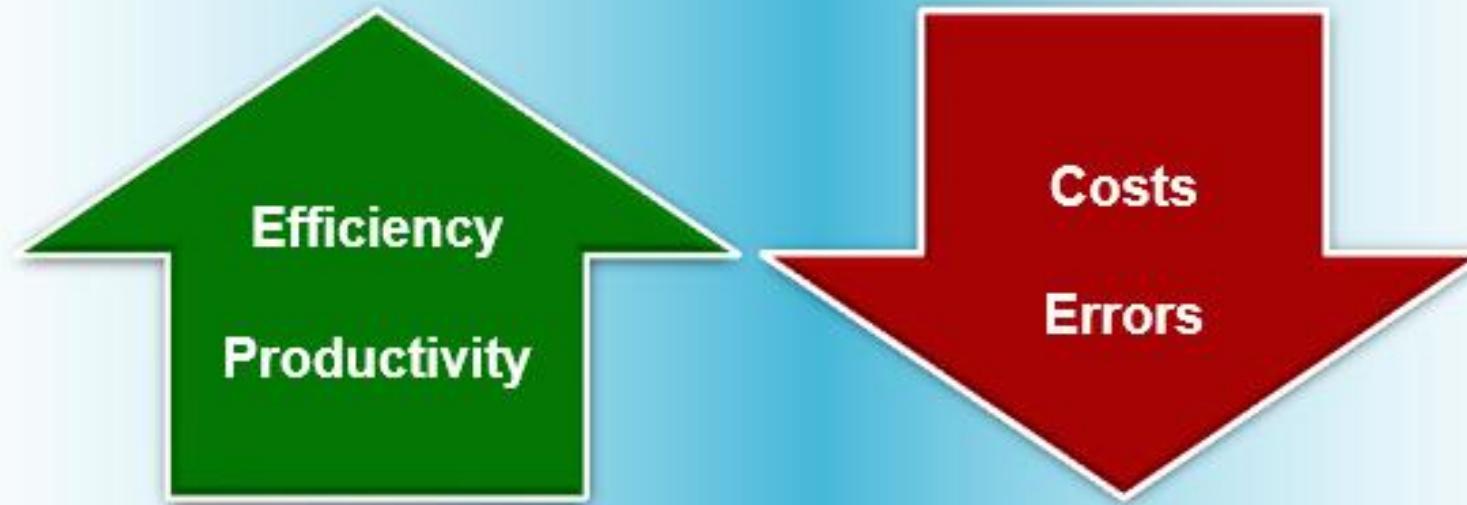
Scalability

Demonstrated scalability:

- Millions of members on a single system



Automation & Configurability



Benefits: Proven Track Record

Proven track record:

- Regulatory compliance
- Lower cost of care
- Administrative efficiency
- Win!



System Architecture Components



The Three Pillars



The Story of You - You got hired at ABC Company!



The Story of You - ABC offers health coverage through U&ME



The Story of You - You sign up for ABC's health plan



The Story of You - ABC sends enrollment information to U & ME



The Story of You - U & ME enters your enrollment into Facets



The Story of You - Facets sends ABC a bill for your premium



HealthCare USA

View Premium and Payment History on-line at:
www.healthcareusa.com

BILLING FOR : ABC COMPANY
ATTN: JOHN DOE
ABC COMPANY
123 MAIN ST. NE
GRAND RAPIDS, MI 49501

DUE DATE : 04/01/2013
BILLING DATE : 04/15/2013

COVERAGE PERIOD FROM : 04/01/2013
THROUGH : 05/01/2013

GROUP ID : C13G00001 (Smart Energy)
SUB GROUP ID : 0001

INVOICE NUMBER : 987654321098

ACCOUNT SUMMARY	
PREVIOUS TOTAL DUE	\$ 29,355.26
OUTSTANDING BALANCE AS OF 11/19/2009	\$ 29,355.26
CURRENT INVOICE	\$ 11,531.76
TOTAL AMOUNT DUE	\$ 40,887.02 PLEASE PAY THIS AMOUNT

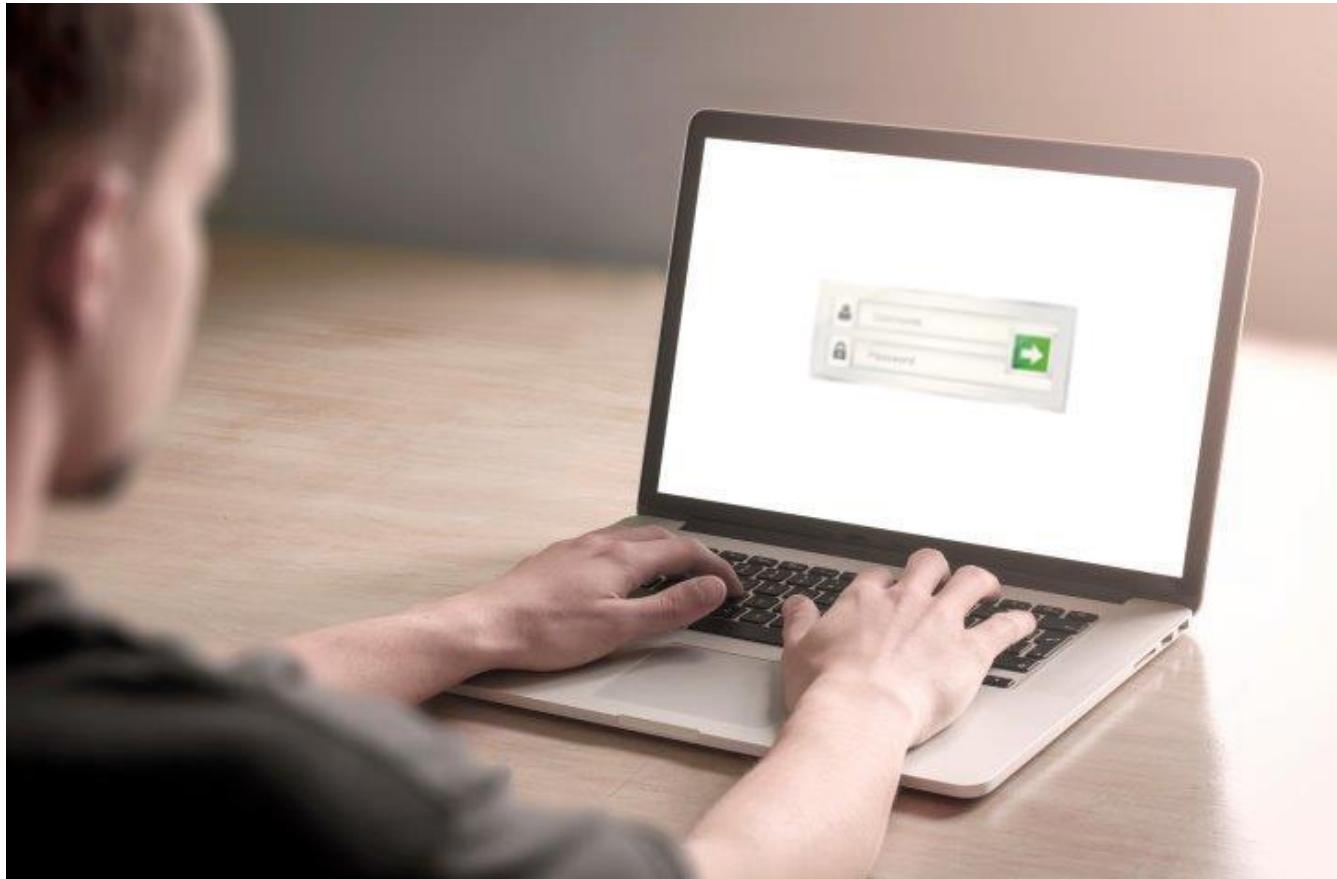
Our records indicate that your premium payment for the previous month has not been received.
Premiums are due on the first of the month for which coverage is provided.

The Story of You - Facets sends you an ID card



Insurance Company Name	COVERAGE TYPE
MEMBER NAME: JOHN DOE MEMBER NUMBER: XXXX-XXX-XXXX	EFFECTIVE DATE: XX-XX-XXXX
GROUP #: XXXX-XXX-XXX	PRESCRIPTION GROUP #: XXXX
PCP CO-PAY: \$15.00 SPECIALIST CO-PAY: \$25.00 EMER. ROOM CO-PAY: \$75.00	PERCRIPTION CO-PAY: GENERIC: \$15.00 NAME BRAND : \$25.00

The Story of You - You work very hard for ABC



The Story of You - You develop carpal tunnel syndrome



The Story of You - You visit the doctor



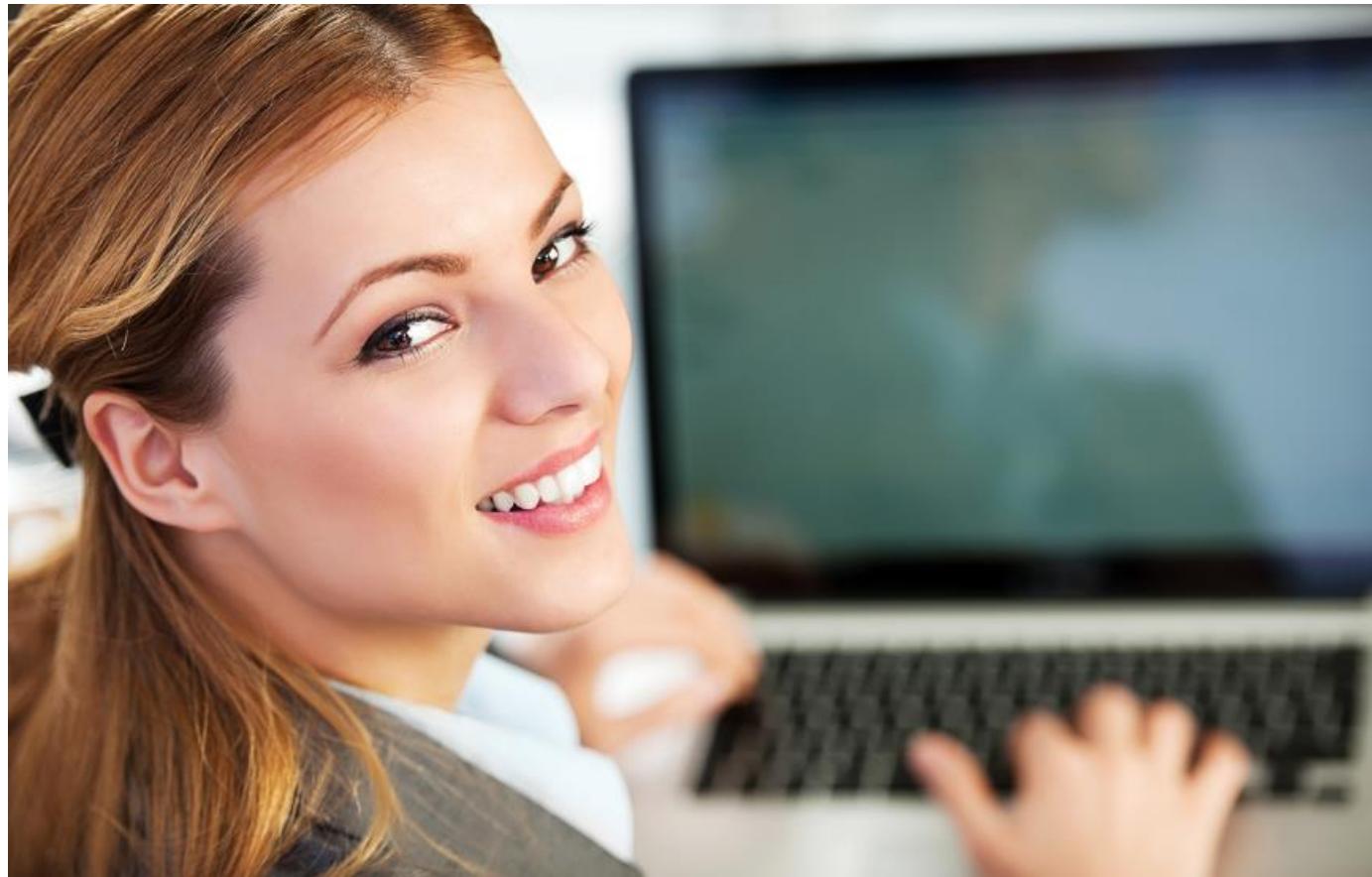
The Story of You - Doctor examines you & recommends surgery



The Story of You - Doctor sends claim to U & ME for the office visit



The Story of You - U & ME processes the claim using Facets



The Story of You - Facets sends the payment to the doctor



The Story of You - Facets sends you explanation of your benefits



The Story of You - Doctor sends request to authorize your surgery



The Story of You - U & ME enters the authorization into Facets



The Story of You - You are anxious, you call U & ME



The Story of You - U & ME answers and records the call in Facets



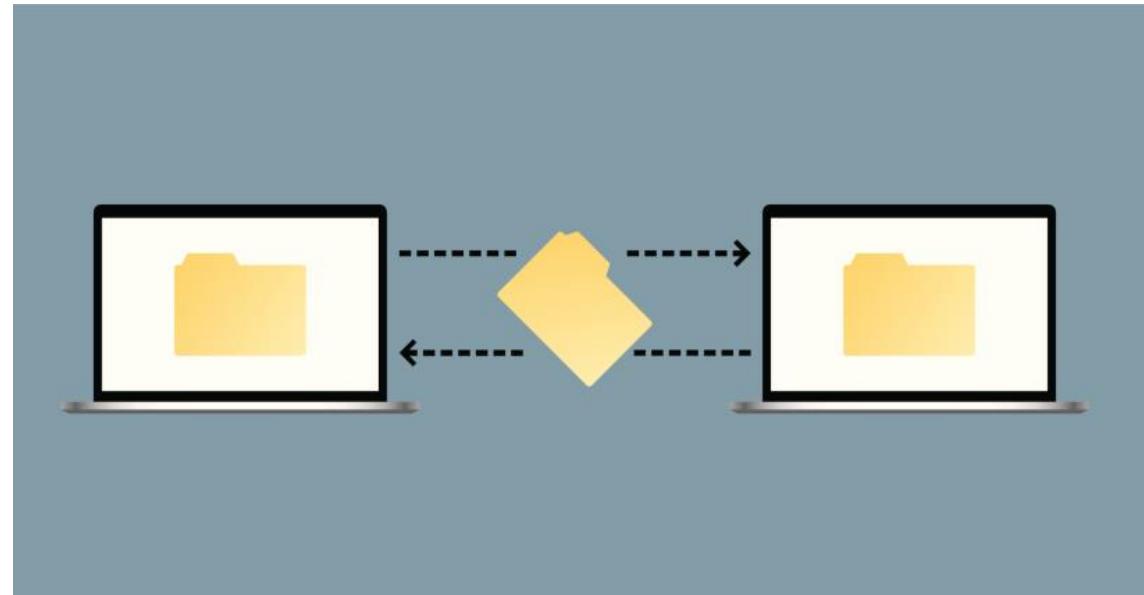
The Story of You - You go to the hospital for surgery



The Story of You - Doctor & hospital send claims to U & ME



The Story of You - Facets auto-matches the claims to the Auth



The Story of You - Facets sends payment to doctor and hospital



The Story of You - Facets sends you an EOB



The Story of You

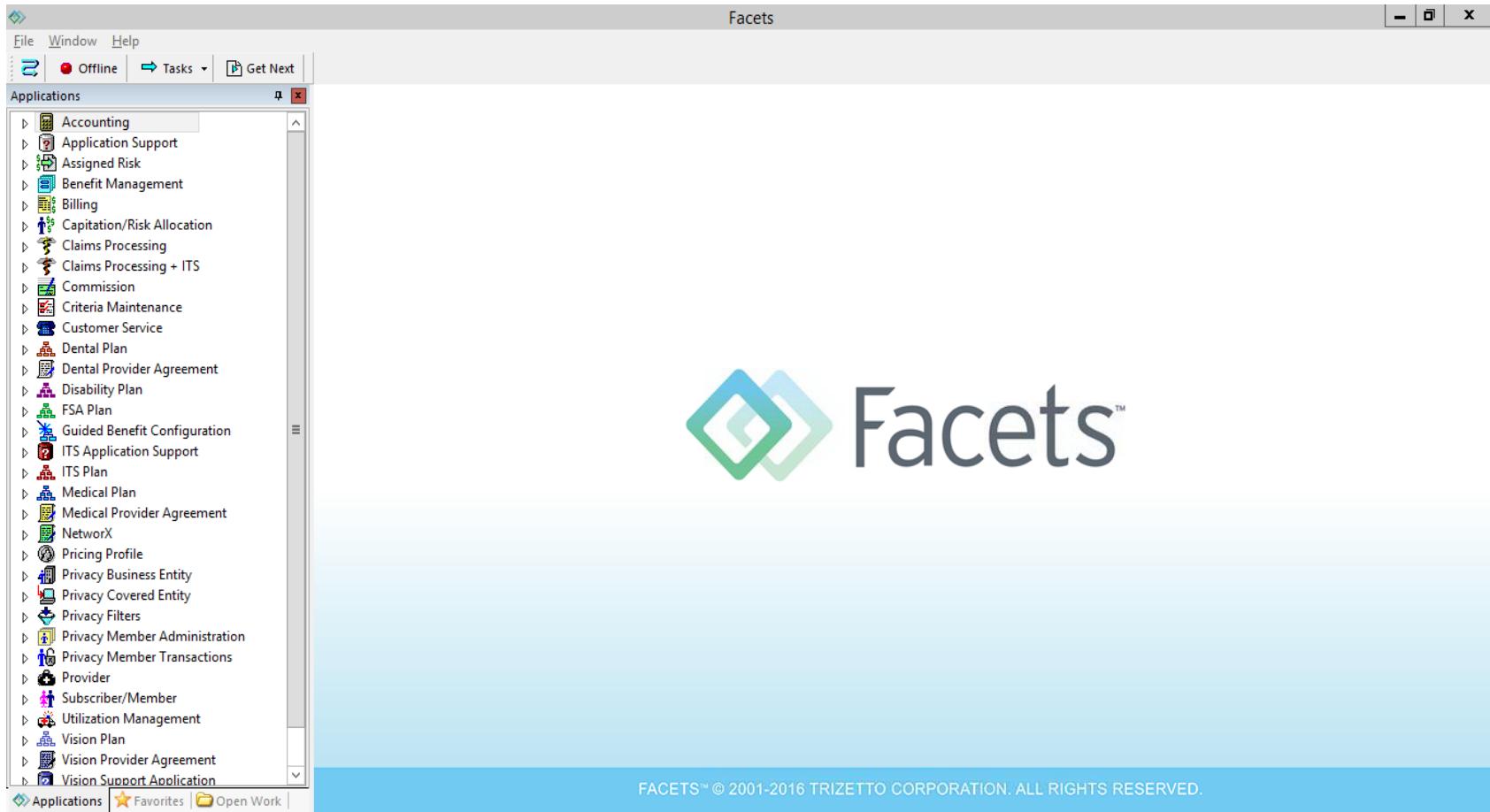


Facets Solution

Modular

Flexible

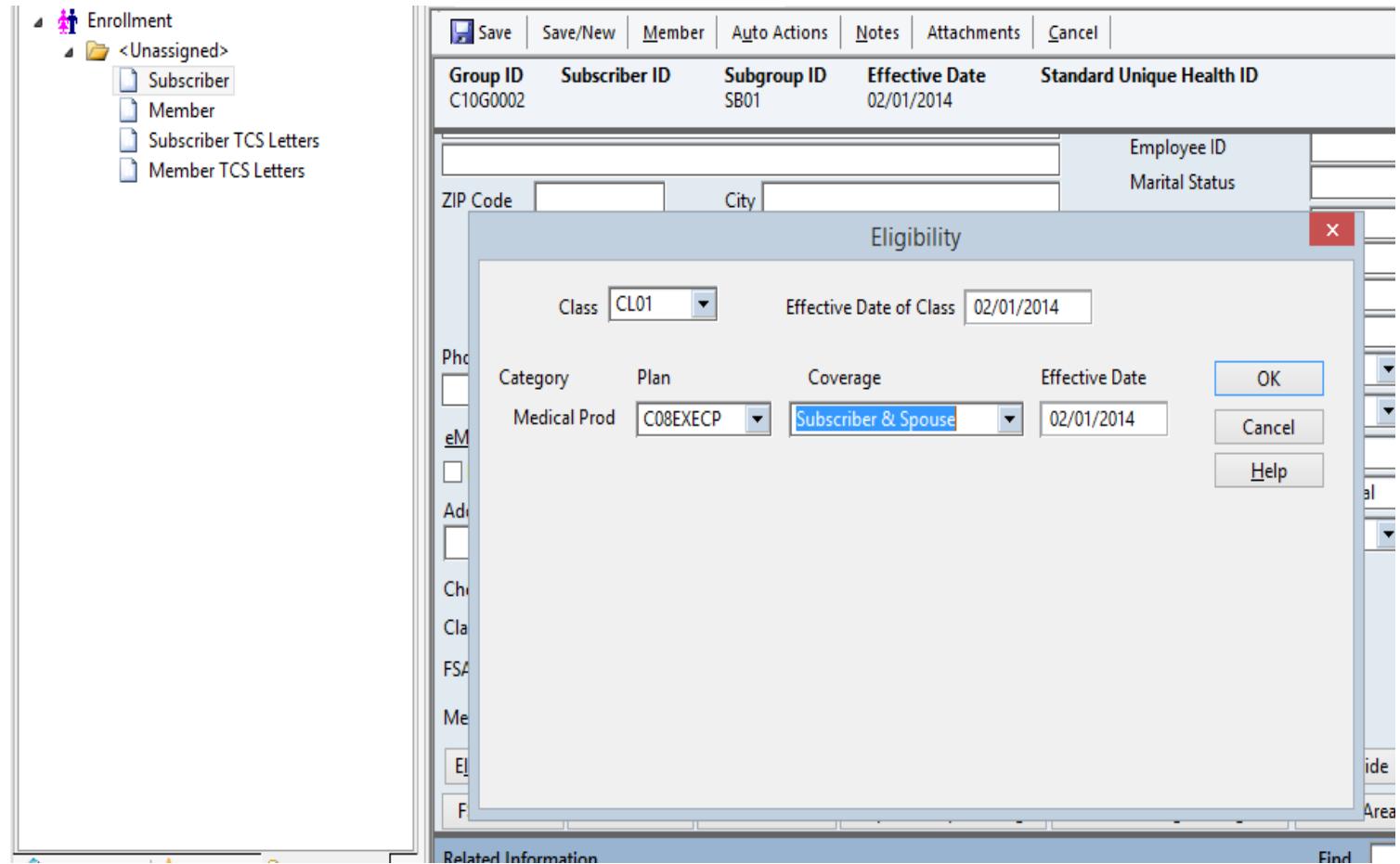
Configurable



Facets Solution: Enroll

Subscriber or member level enrollment

Real-time, batch or manual submission choices



Facets Solution: Bill

Group or Individual billing based on:

- Premium rate factors
- Cost of claims
- Capitation
- Volume

Automatic reconciliation:

- Based on membership changes

Commission calculation and payment

Group ID	Subscriber ID	Number of Due Dates to Return		
C07G0002	090100001	All		
Due Date	End Date	Invoice Create Date	Invoice Number	Destination
06/01/2011	06/30/2011	04/01/2012	121240027	Printer
05/01/2011	05/31/2011	04/01/2012	121240026	Printer
04/01/2011	04/30/2011	04/01/2012	121240025	Printer
03/01/2011	03/31/2011	04/01/2012	121240024	Printer
02/01/2011	02/28/2011	04/01/2012	121240023	Printer
01/01/2011	01/31/2011	04/01/2012	121240022	Printer
12/01/2010	12/31/2010	04/01/2012	121240021	Printer
11/01/2010	11/30/2010	04/01/2012	121240020	Printer
10/01/2010	10/31/2010	04/01/2012	121240019	Printer
09/01/2010	09/30/2010	09/02/2010	102720001	Printer

Indicative Contract Subtotals Plan Totals Component Totals Component Information Fees/Discount:

Total Billed Amount \$130.00	Bill Type Individual Direct
Total Received Amount \$0.00	Number of Active Subscribers 1
Total Subsidy Amount \$0.00	
Current Payment Status Unpaid	
Delinquency Date 04/01/2012	
Number of Days Billed 30	Prorate Factor No
Prorated Bill	
Special Bill Final Bill	
Last Archive Date	
Reconciliation Status Not Applicable	
Reconciled by User ID	Not Assigned

Facets Solution: Pay

Automated processes:

EDI

Claims Edits

- Eligibility
- Benefits
- UM requirements

Extensibility:

Clinical editing

Claims editing

Fully integrated with NetworX Pricer ®, CAE and Workflow

Claim ID	Provider ID	Status	Next Rev Date	Payee	Notes Exist				
072190000300	C07000002201	02 Accepted; Batch Complete	Unassigned	Provider					
		Total Charge	\$425.00	Patient Paid	\$0.00				
	From	To	POS	TOS	Proc	Diagnosis	Charges	Units	^
-->	06/15/2007	06/15/2007	11	VO	99213	487	\$125.00	1	
2	06/15/2007	06/15/2007	11	RDO	70015	487	\$100.00	1	
3	06/15/2007	06/15/2007	11	RDO	70250	487	\$200.00	1	▼
		Overrides	Sub/Mem	COB	Match UM	EOB	Sign/Payee		
Accum Limits Claim Detail Clinical Notes Duplicate Claim Line Item Price Calculation Provider Detail Split Payment UM									
Considered Charge	\$125.00	Deductible	\$0.00	Discount Amount					
Allowed Units	1	Copay	\$15.00	Supplemental Discount					
Allowed	\$125.00	Coinsurance	\$11.00	COB Adjustment					
Benefit	\$99.00	Disallow	\$0.00	Withhold Amount					
HRA Paid	\$0.00			Patient Liability Disallow					
FSA Paid	\$0.00			Total Patient Liability					
Type of Service	Practitioner Visit Outpatient								Network Indicator
<hr/>									
Claim Totals	\$425.00	Deductible	\$0.00	Discount Amount					
Charges	\$425.00	Copay	\$15.00	Supplemental Discount					
Allowed	\$125.00	Coinsurance	\$11.00	COB Adjustment					
Benefit	\$99.00	Disallow	\$300.00	Withhold Amount					
				Patient Liability Disallow					
				Total Patient Liability					

Facets Solution: Customer Support

Automatic actions initiate contact with members:

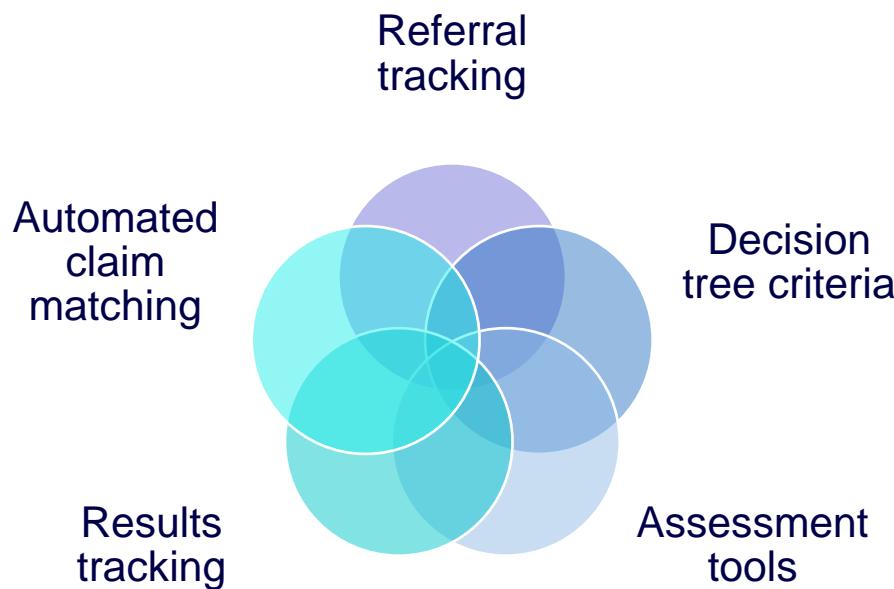
- Programs
- Information

Customer Service application group:

- Answer inquiries
- Request information

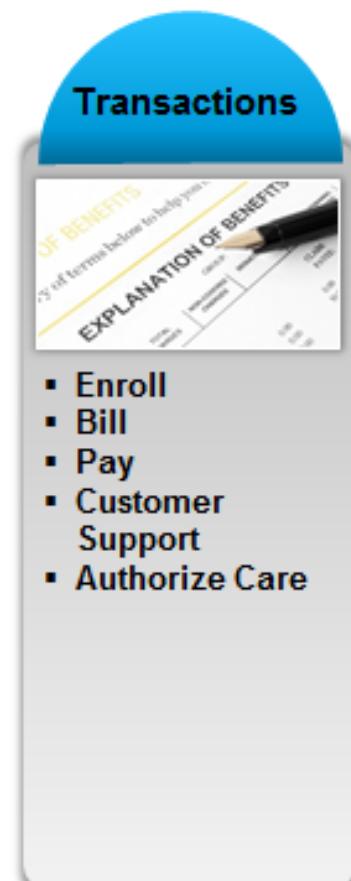
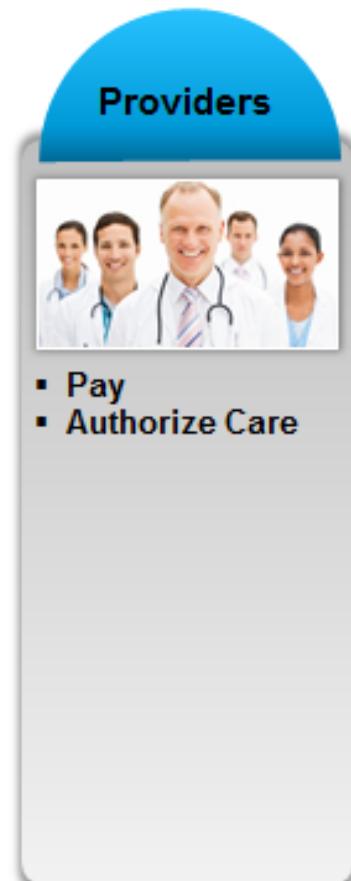
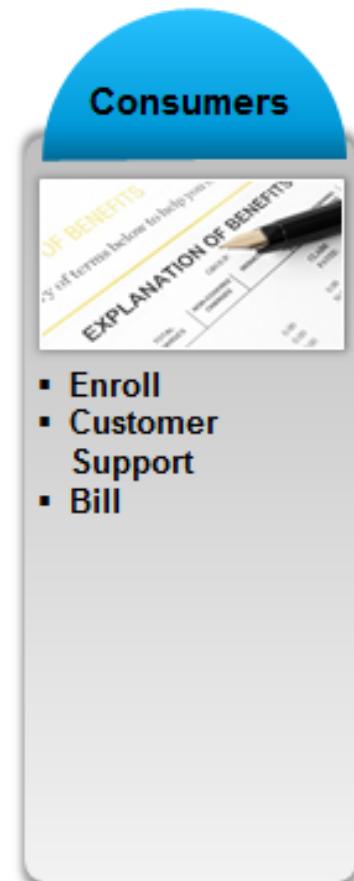
The screenshot shows a software interface for customer support. At the top, there is a navigation bar with links: Start / Task List, End Call, Appeal Intake, Benefit Summary, Calendar Events, Cart, Contact Info, Provider, and Related Not. Below the navigation bar, there is a header row with columns for Customer Service (containing the value 150212000000), Contact Name (containing the value a c), Contact Phone, Ext., Contact Type (containing the value CAL1 - Member), Method (containing the value 1 - Call In), and Notes (containing the value Member, Subscr). On the left side, there is a vertical sidebar with various application groups: Address, Attachments, Bill Summary, CDH Account, COB, Deductible, Dental Accum, Dental Claims, Disability, Eligibility, FSA Accum, FSA Claims, General, HRA Accum, Limits, Medical Claims (which is currently selected and highlighted in blue), and Medicare. To the right of the sidebar, there is a search panel with fields for Subscriber (containing the value 070700003), Member (containing the value Antonio Carucci - 00 - Subscriber 05/01), Provider ID, Prv Name, Claim ID, SCCF ID, Dates (containing the values 01/01/2010 to 03/31/2015), and Refresh button. Below the search panel, there is a section titled "Medical Claim History from 01/01/2010 to 03/31/2015 - Found 0026" which displays a table of claims. The table has columns: Claim ID, Low DOS, High DOS, Total Charge - Claim, Status - Claim, and Name. The first five rows of the table are visible, showing claims with IDs 100270000100, 100270000101, 100270000200, 100460000100, and 100460000200. The last row is partially visible. The row for claim ID 100270000200 is highlighted with a blue background. At the bottom of the interface, there is a tree view with the root node "Claim No - 100270000200" expanded, showing child nodes: Claim Data, Claim Lines, Payee Remit Detail, Hospital, Supplemental Claim Data, Encounter Data Codes, and Encounter Line Data.

Facets Solution: Authorize Care



Claims Inquiry - All								
Search Parameters	Subscriber ID/Sfx 070700003	Provider ID 00 N/A	Service Dates		From	To	Rows	78
Member	Provider	Begin	Charges	Paid Amount	Status	Paid D		
Antonio Carucci	Community Hospital at Dobbs Ferry	03/16/2010	\$6,000.00	\$6,000.00	02 - Accepted; Batch Complete	05/06/2010		
Antonio Carucci	Community Hospital at Dobbs Ferry	01/12/2010	\$3,000.00	\$175.00	02 - Accepted; Batch Complete	05/05/2010		
Antonio Carucci	Community Hospital at Dobbs Ferry	01/12/2010	\$3,000.00	\$0.00	02 - Accepted; Batch Complete	05/05/2010		
Original Data Overrides - Claim Overrides - Line Item Products & Prefixes Redirect Remittance Rendering Providers Status UM Match Details								
From	To	POS	TOS	Procedure	Diagnosis	Charges	Units	
01/12/2010	01/14/2010		RB	44950	7890	\$3,000.00	1	
Referral	Admit	Exp.Dschrg	Discharge	Days Auth	Days Paid	Status		
PreAuth	03/14/2006	03/17/2006	03/17/2006	3	0	DC		
UM Ref ID 072210001 Facility Community Hospital at Dobbs Ferry Adm. Provider Req. Provider Andersen, Morgan A. Diagnosis 7890 Abdominal Pain Discharge Dx 7890 Abdominal Pain Surgical Proc. 44950 Appendectomy; Surgery Date Place of Svc. 21 Inpatient Hospital Actual LOS 3 DRG								
Status Discharged Status Reason Pend for physician review Denied Disallowable Treatment Surgical Type of Care Urgent Out of Area In Area Case Mgmt. ID C07000001 Primary IIM User harmeln								

Three Pillars: Review



The Four Imperatives

Achieve Compliance



- HIPAA Privacy Suite
- ICD-10
- 5010
- FARM

Cost, Quality, Delivery of Care



- CDH
- VBB
- Provider Programs

Admin Efficiency



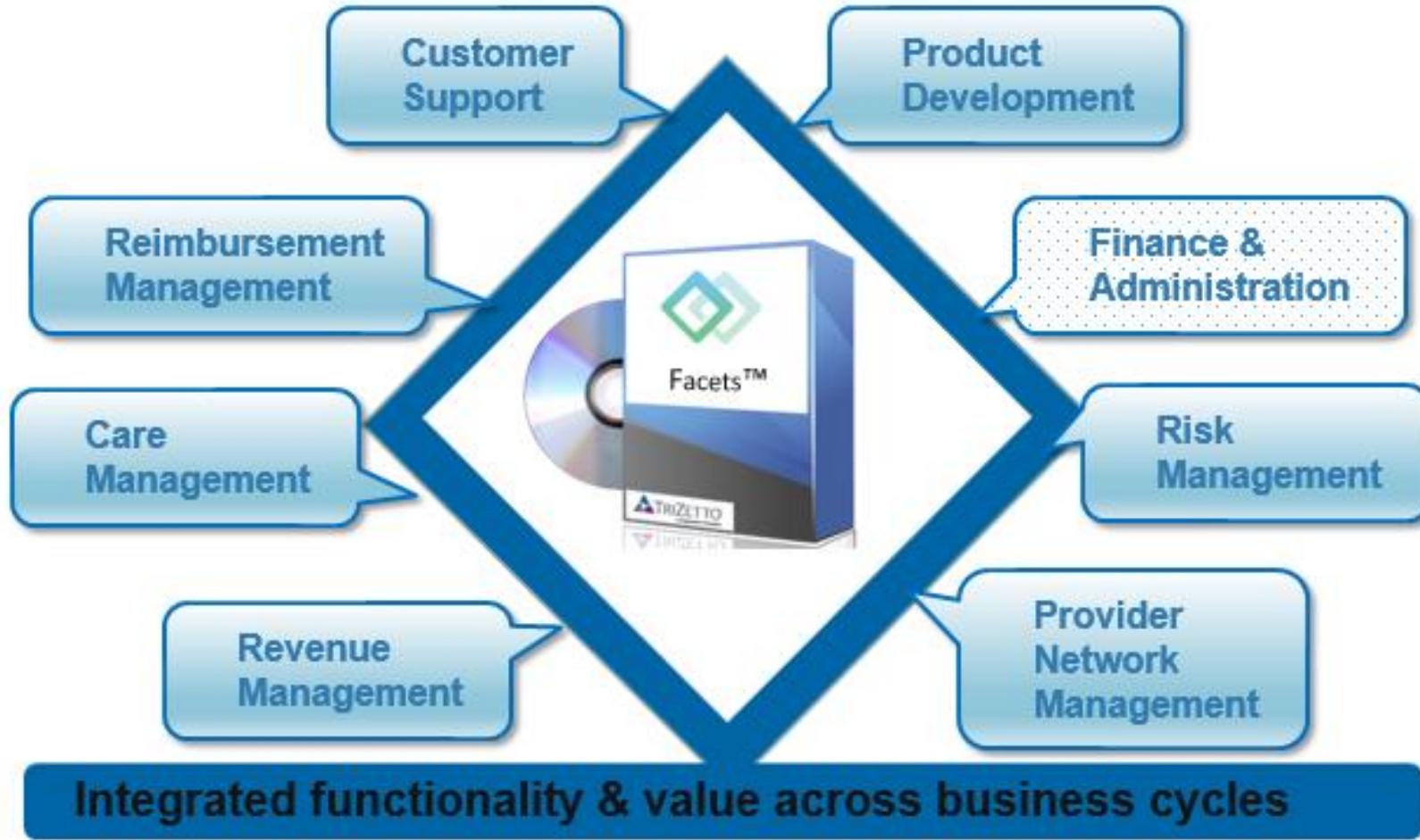
- Workflow
- Billing
- ITS Processing

Compete to Win



- Medical Plans
- Dental Plans
- Disability Plans
- Vision Plans
- Medicare
- Medicaid

Facets End to End Functionality

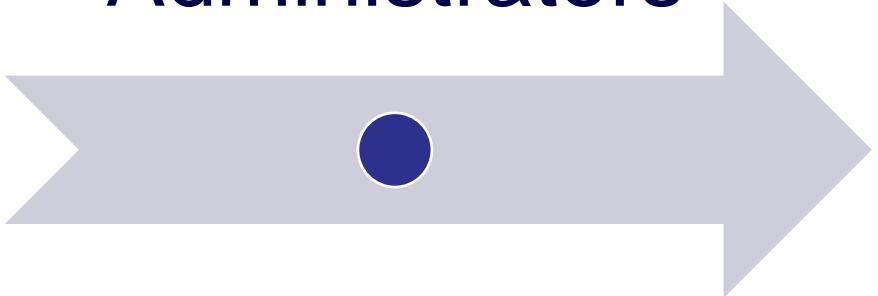


Who uses Facets?

THINK	KNOW	LEARNED

Who uses Facets? Enroll & Bill Functions

Group
Administrators



Who uses Facets? Pay Function

Benefit Administrators



Claims Analysts



Provider Representatives



Who uses Facets? Customer Support Function

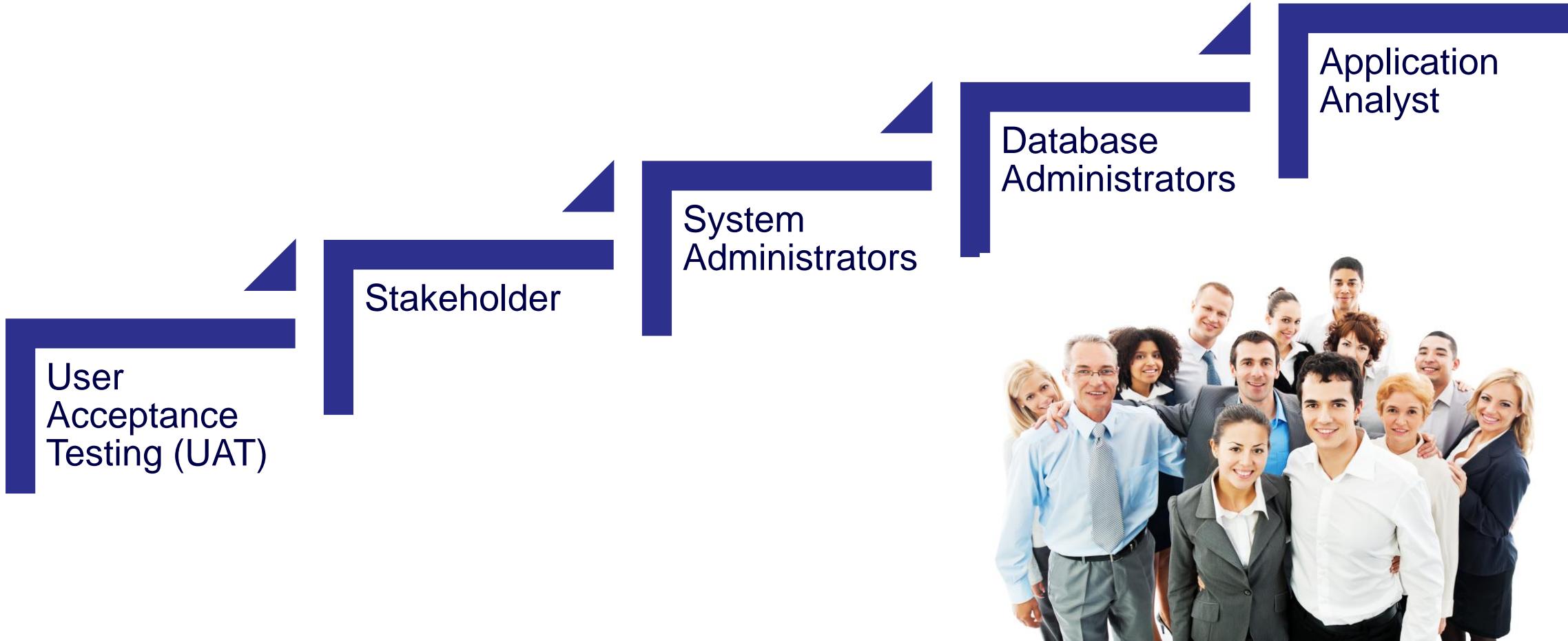
Customer
Service Reps

Appeals
Coordinators

All departments



Support Roles



Lesson Objectives

You are now able to successfully describe:

- Benefits
- Required system architecture
- Features and functions
- Roles of users
- Necessary support roles

Questions??



Thank you!!



Healthcare Basics

Learning Services



Agenda

- Healthcare Introduction
- Historical Overview
- Current Trends
- Key Terminologies & Definitions
- Healthcare Entities
- Healthcare Ecosystem
- CDHP
- Provider Credentialing
- Utilization Review
- Claim Decision Process
- Laws & Programs

Introduction – Healthcare Terms



Introduction – Healthcare Terms – Contd..

Member

The beneficiary who is enrolled with a Payer and receives the healthcare service.

Payer

Typically the health plan who manage the health care service and pay for the services

Provider

The medical practitioner, Hospital, Labs, Tertiary care services etc. that provides Health care Service

Sponsor (Billing Entity)

The entity who pays premium to Payer. Can be Employer Group, Individual family member etc..

Introduction – Healthcare Terms – Contd..

Insurance

- Insurance whereby the insurer pays the medical costs of the insured if the insured requires medical services

Managed Healthcare

- A system that manages financing and delivery of healthcare services. Typically, managed care systems rely on a primary care physician who acts as a gatekeeper for other services, such as specialized medical care, surgery, and physical therapy

Health Insurance Policy

- a contract between an insurer and an individual or group, in which the insurer agrees to provide specified health coverage at an agreed-upon price (**the premium**)
- Health insurance usually provides either direct payment to doctors and hospitals for services provided or reimbursement for expenses associated with illnesses and injuries

Key Terminologies & Definitions

Policy

- Contract between the payer and the subscriber

Cost shifting

- Practice of charging more for services provided to paying patients or third-party payers to compensate for lost revenue resulting from services provided free or at a significantly reduced cost to other patients

Premium

- Monthly/Quarterly/half yearly/yearly payments which the subscribers make to the Payers

Network

- Group of physicians, hospitals, and other medical care providers that a specific health plan has contracted with to deliver medical services to its members

Coordination of Benefits [COB]

- Non duplication of benefits provision.

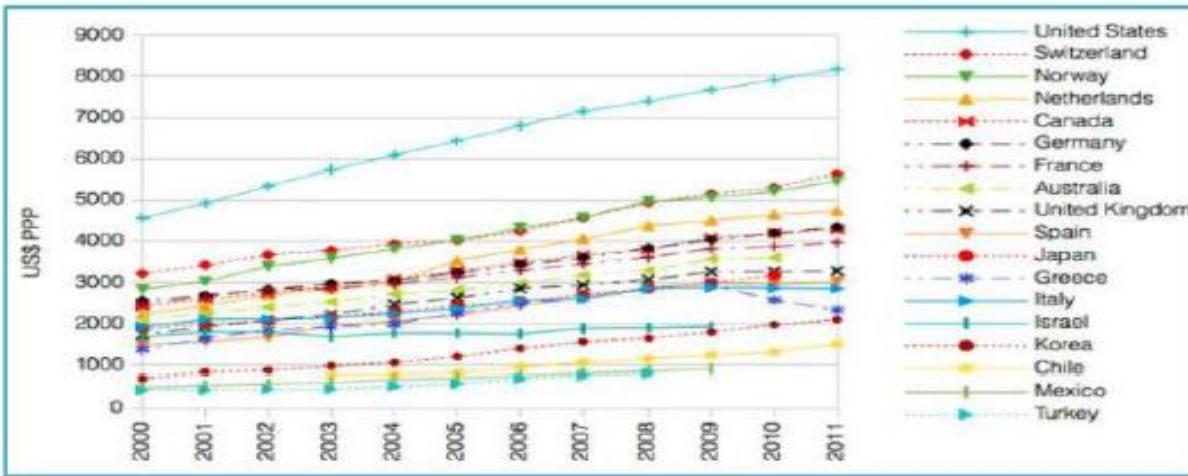
Benefits

- Coverage provided by the insurer as per the policy

Historical Overview

U.S. Healthcare – Expenditure and Quality of Care

US Healthcare is increasingly becoming unaffordable. The expenditure is expected to grow that in turn limits the stress of public resources.



Source: OECD Health Statistics, 2013

Health expenditure per capita by country, 2011

U.S. is the most expensive healthcare system in the world.
It spends \$8,508 per person on healthcare, nearly \$3,000 more per person than Norway, the second-highest spender.
But ranks 11th in overall quality of healthcare

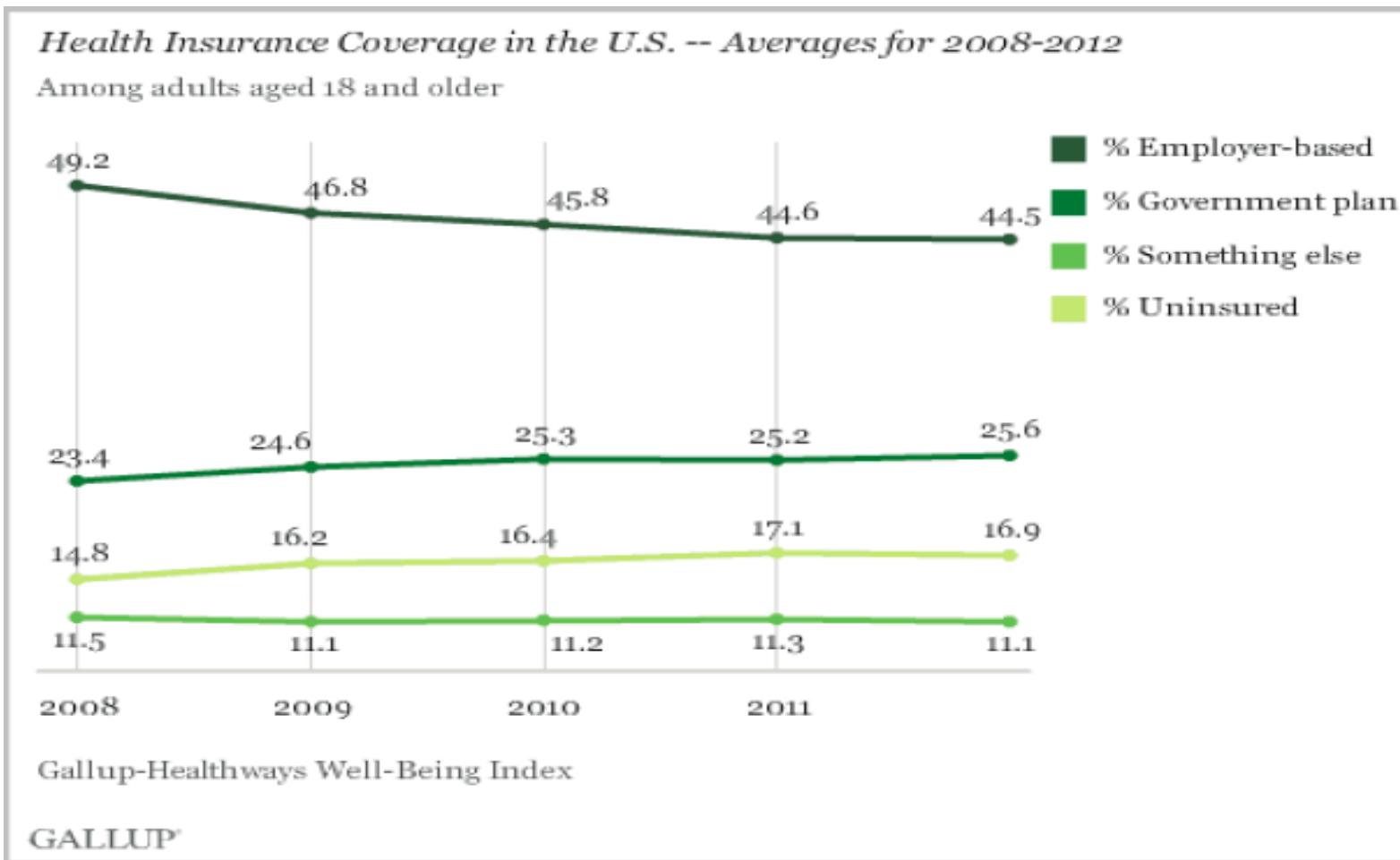
In 2018, the US\$PPP
was 10209

PPP – Purchasing Power Parity

OECD – Organization for Economic Cooperation and Development

Historical Overview – Contd..

U.S. Healthcare – Expenditure and Quality of Care



Evolution of US Healthcare

Industrialization



Need for Healthcare



1900

Industrialization

Evolution of US Healthcare – Contd..

The Great Depression



Healthcare Advances

1920s
Great Depression

1900
Industrialization



Evolution of US Healthcare – Contd..

Increased Costs



Healthcare Insurance

1920s
Great Depression



Evolution of US Healthcare – Contd..

Employment Benefits



Third-Party Payers

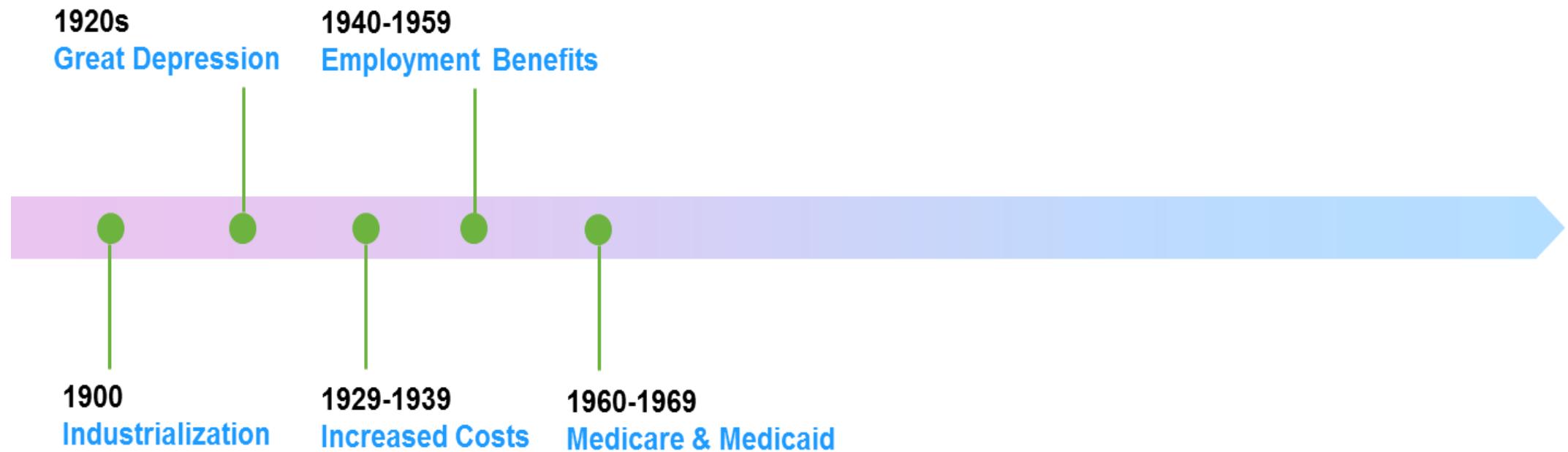


Evolution of US Healthcare – Contd..

Medicare & Medicaid



Government Programs

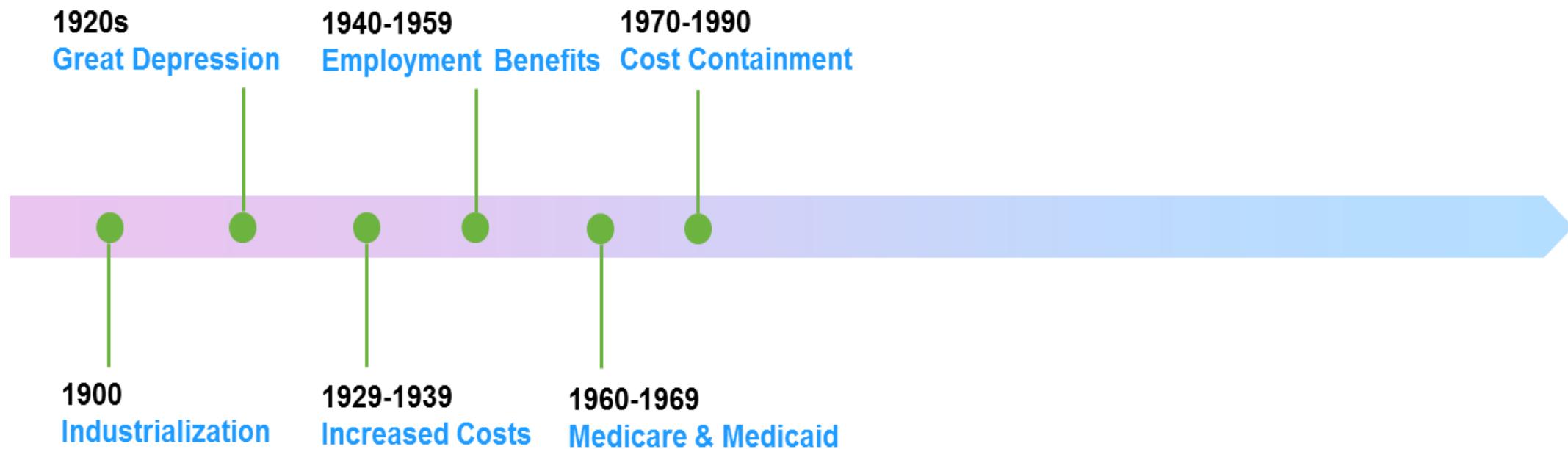


Evolution of US Healthcare – Contd..

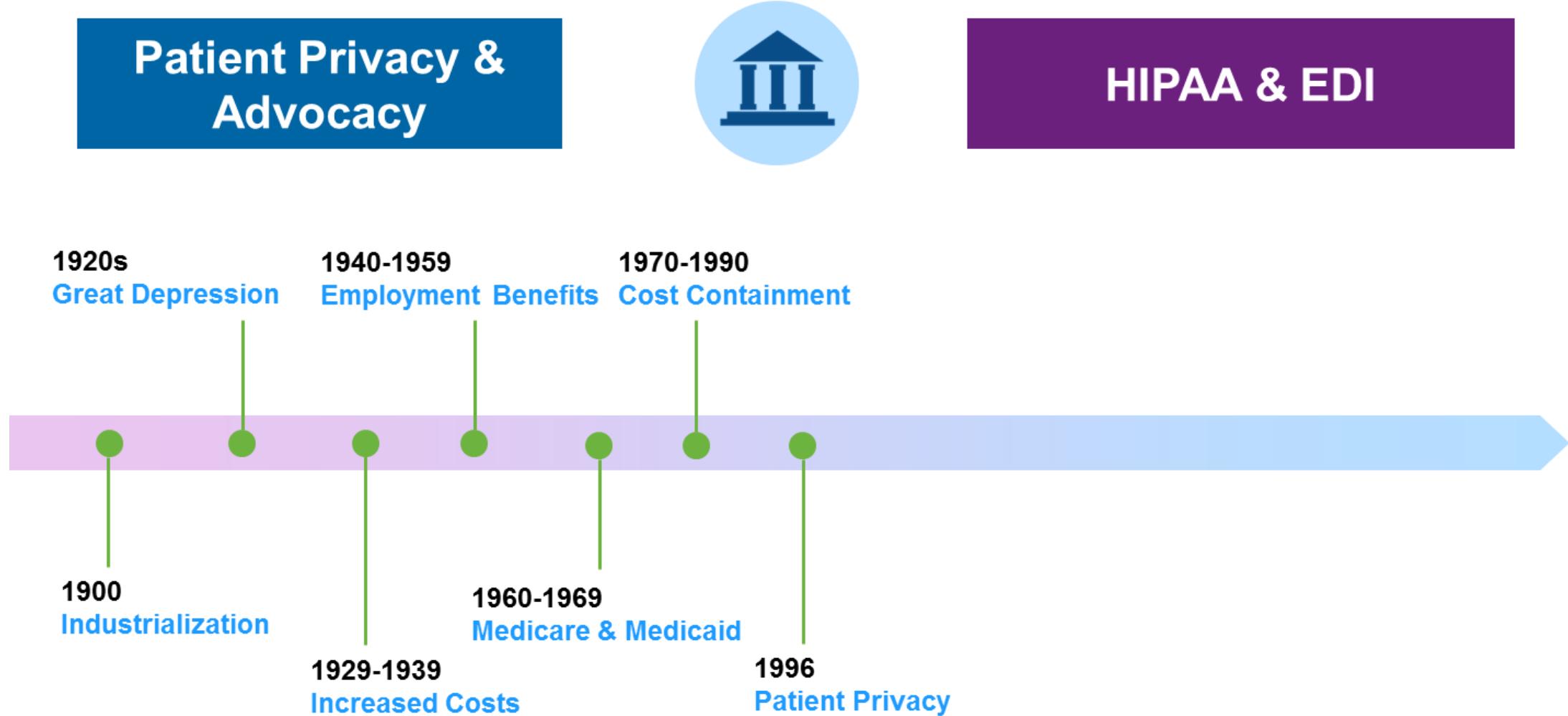
Cost Containment



Health Maintenance Organizations (HMO)



Evolution of US Healthcare – Contd..

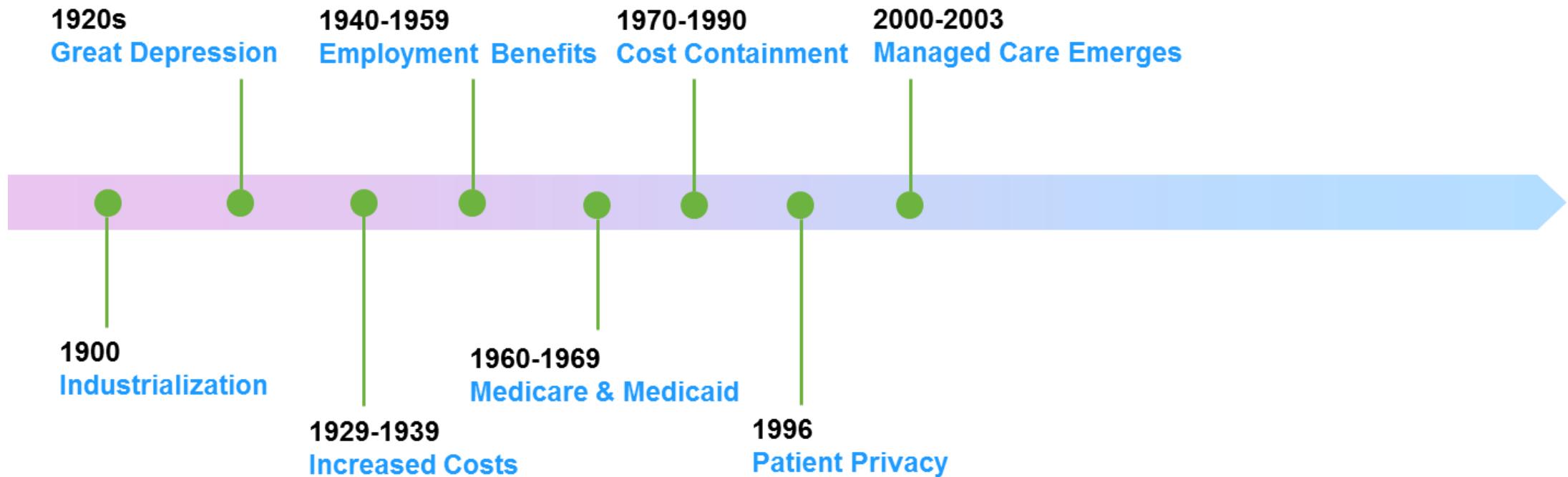


Evolution of US Healthcare – Contd..

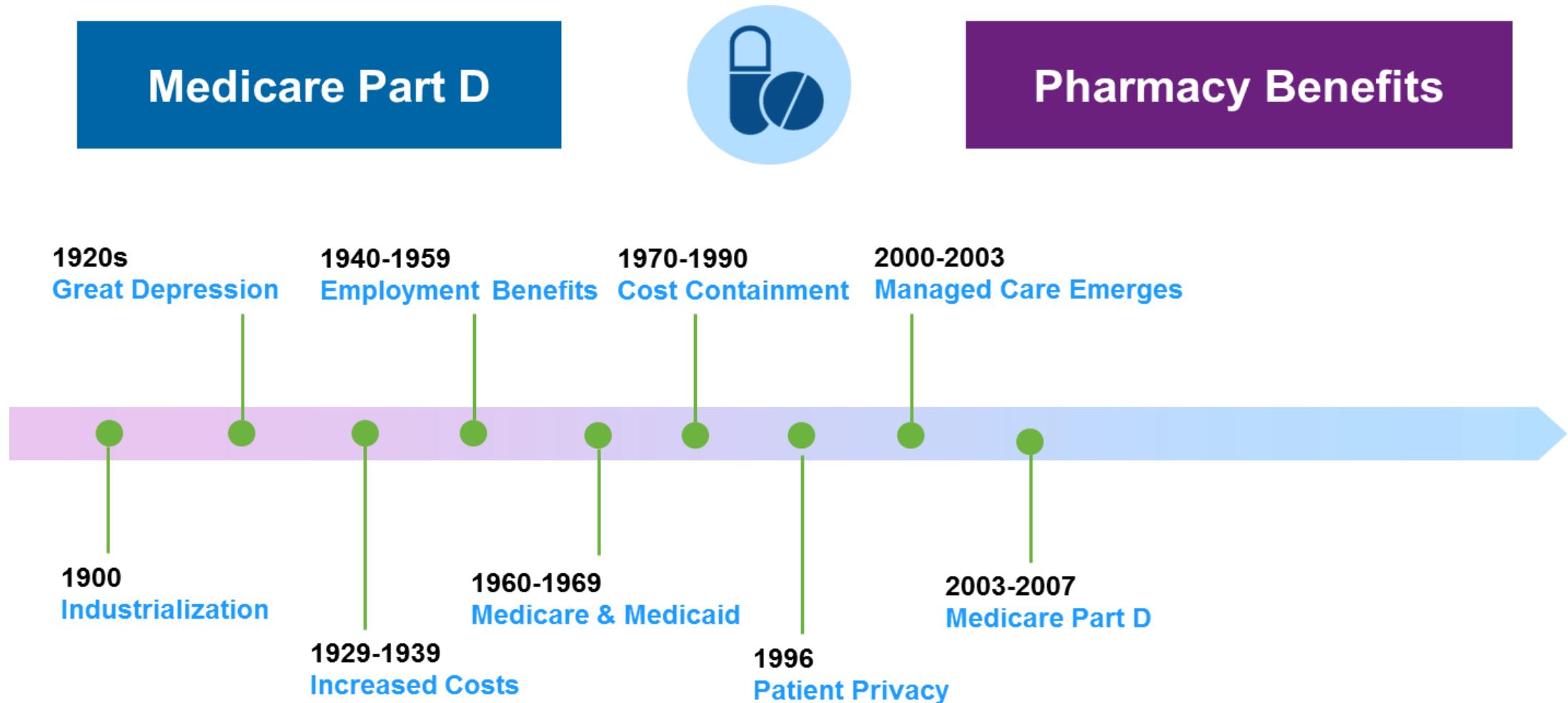
Managed Care
Emerges



Shift to PPOs



Evolution of US Healthcare – Contd..

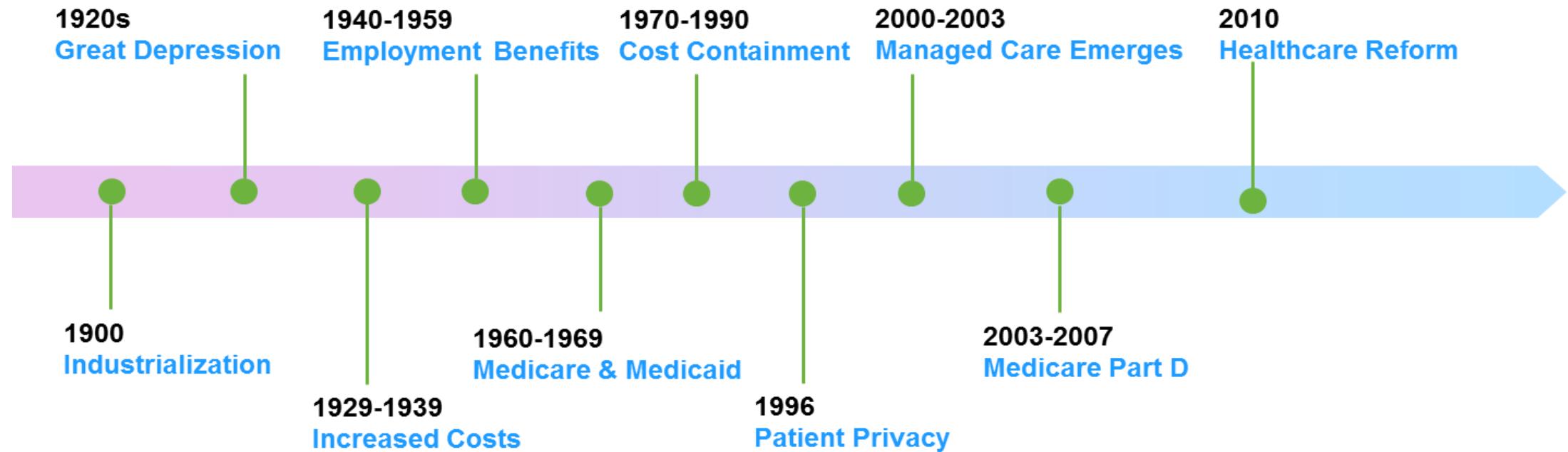


Evolution of US Healthcare – Contd..

Healthcare Reform



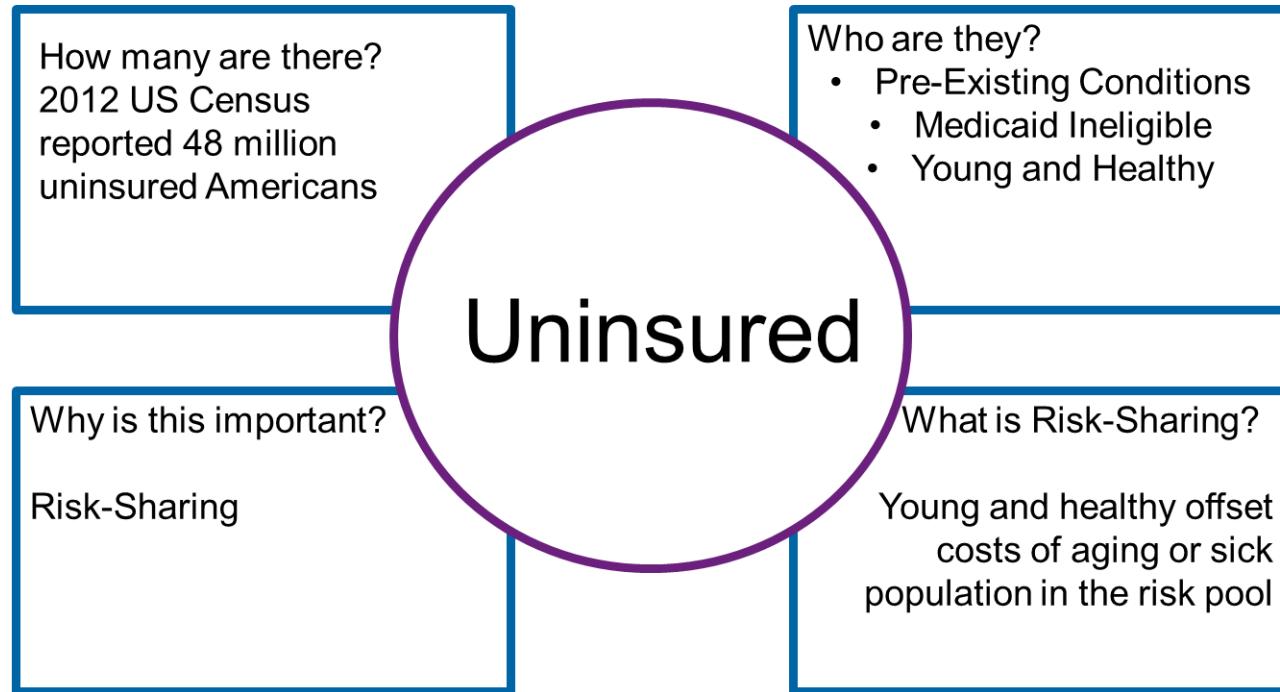
Third-Party Expansion



Issues Affecting HC Environment

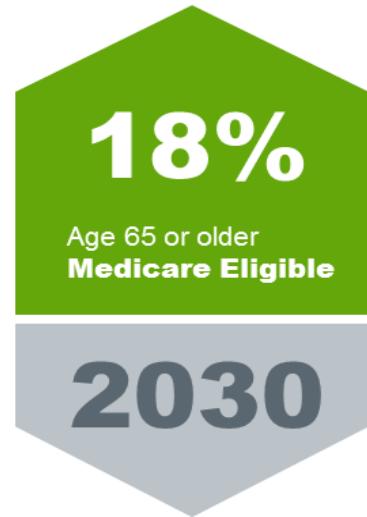
- Continued rise in the cost of healthcare services and in turn, health insurance premiums
- United States spends more on healthcare than any other industrialized nation, yet the population is not healthy in comparison
- Shift to Consumer Directed Healthcare (high-deductible plans), Health Savings Accounts (HSAs), Flexible Spending Accounts (FSAs)
- 48 million Americans without healthcare coverage
- Continued rise in chronic conditions and obesity
- Baby boomer generation moving from employer-sponsored healthcare to Medicare

Issues Affecting HC Environment – Contd..



Issues Affecting HC Environment – Contd..

Each day, 10,000 people, will turn age 65 from 2010 to 2029



Compared To...



Baby Boomers

Current Trends

Healthcare Trends in the U.S.	
<p>The chart below shows some of the healthcare trends followed in the U.S.</p>	
Emergence of ACOs	<ul style="list-style-type: none">Focus on health of population15-17% of the U.S. population is being served by 522 ACOs
Financing and delivery of care	<ul style="list-style-type: none">Public-private sector partnerships expansion, creating a multi-trillion global market for the private sector and helping governments provide sustainable healthcare for their citizens
New models of integration	<ul style="list-style-type: none">Vertical integration, blurring the lines between providers and payers (HIX)Strategic orchestration, Hospital Collaborative
Patient engagement and Consumerism	<ul style="list-style-type: none">Move towards precision-based industry - more personal, predictive and preventiveDigital health – mHealth, mWellnessTransparency of price, quality and outcomes
Digital transformation	<ul style="list-style-type: none">SMAC, Big data and CMS's "data liberacion"Combining clinical, social and other data to drive health intelligence
Connected health	<ul style="list-style-type: none">Tele-health and tele-medicine; home monitoringHIE, eHealth 2.0
Cost takeout	<ul style="list-style-type: none">Emergence of MLRManaging tail-risk, Operational efficiencies to support changing service mix
Staffing shortage	<ul style="list-style-type: none">Influx of 25 million newly insured patients over the next decade leading to physician shortage
Governance and leadership gap	<ul style="list-style-type: none">Changing mindset of the board from volunteer and community service to commercial and technically savvyPhysician leadership

Deductibles

Out-of-Pocket (OOP) Expenses

Amount of out-of-pocket expense paid by member before plan pays

Member pays 100% of plan-approved fee up to deductible amount

Deductibles

Coinsurance

Out-of-Pocket (OOP) Expenses

Amount member pays to healthcare provider for medical services:

- Based on health plan's approved fee
- Plan pays a percentage
- Member pays remainder



Coinsurance

Copay

Out-of-Pocket (OOP) Expenses



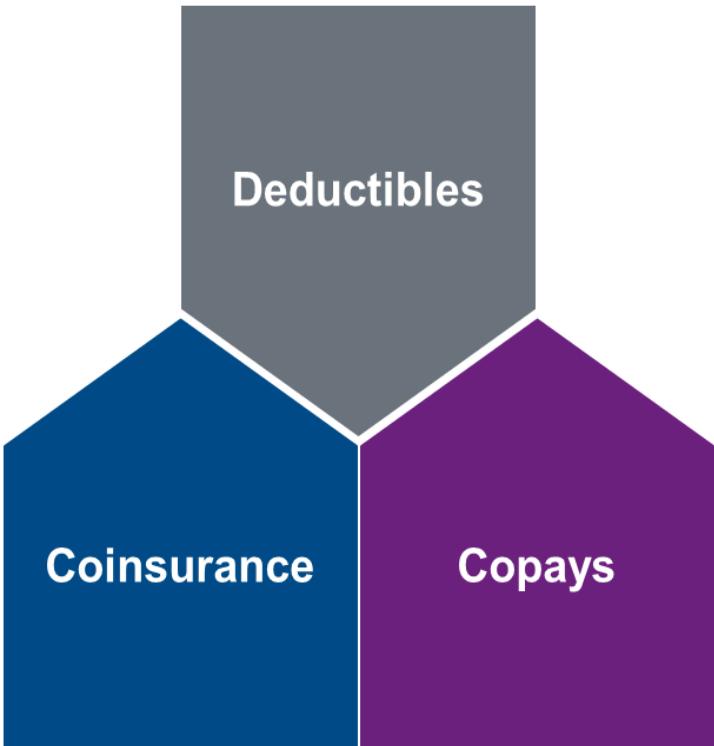
Fixed dollar amount paid by beneficiary

Due at time of service

Services such as office visits, chiropractic services, etc.

Out-of-Pocket Expenses

Out-of-Pocket (OOP) Expenses



The total payment towards eligible expense that member funds. i.e., Deductible, Co-pay & Coins as defined by the plan benefit.

Key Terminologies & Definitions– Contd..

Claims

- The process of raising the expense incurred for rendering a service to the Health plan
- Typically raised by Provider. Member can also raise claims

Eligibility

- The status of a member when the defined plan benefits is applicable to the member.

Accumulator

- The rolling up of total amount/units met for Deductible or Out of pocket during each service in given period (calendar year, plan year etc...)

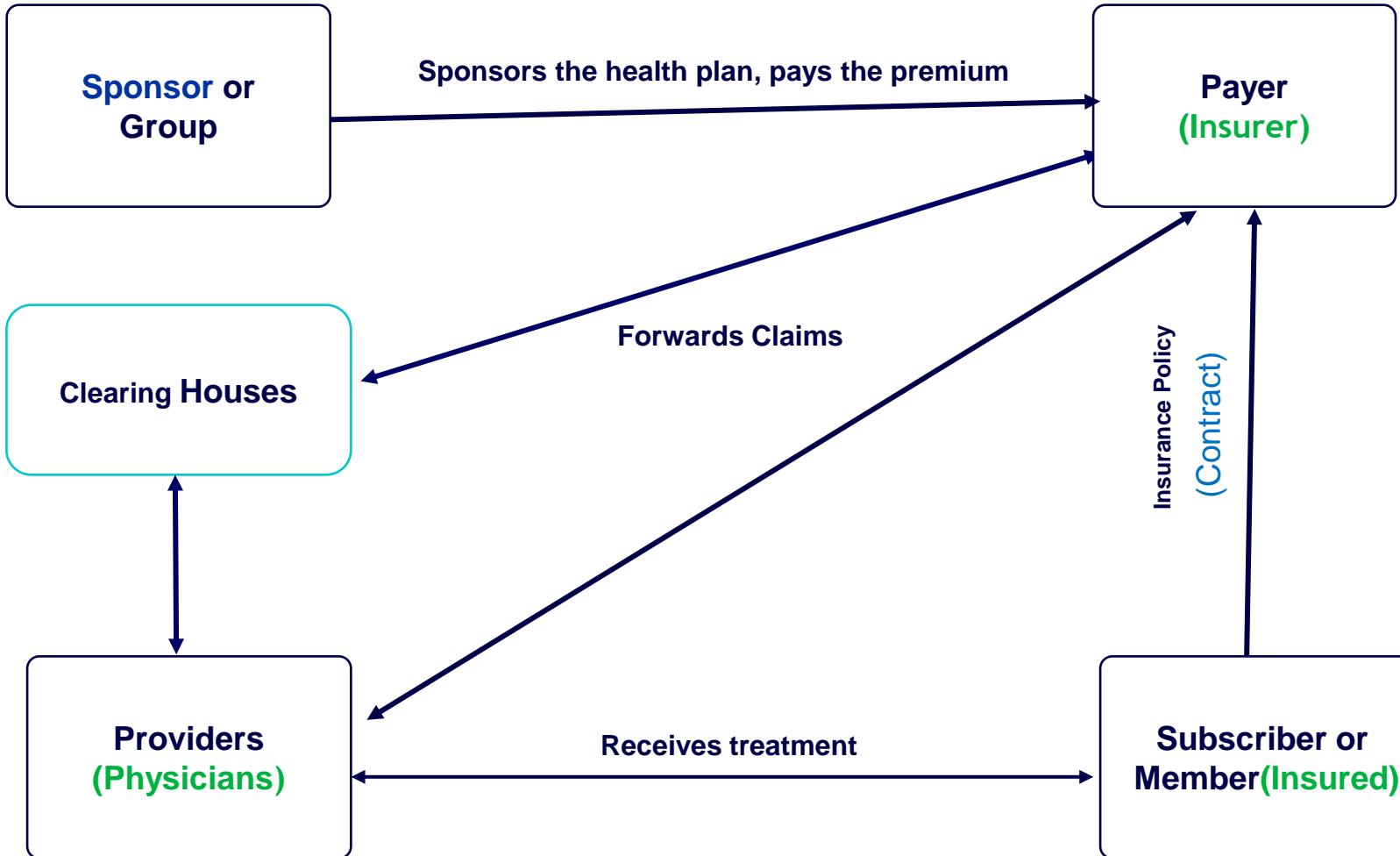
Capitation

- A risk-sharing payment arrangement in which set amount is paid to Provider for each enrolled person assigned to them, per period of time, whether or not that person seeks care.

Pre-existing condition

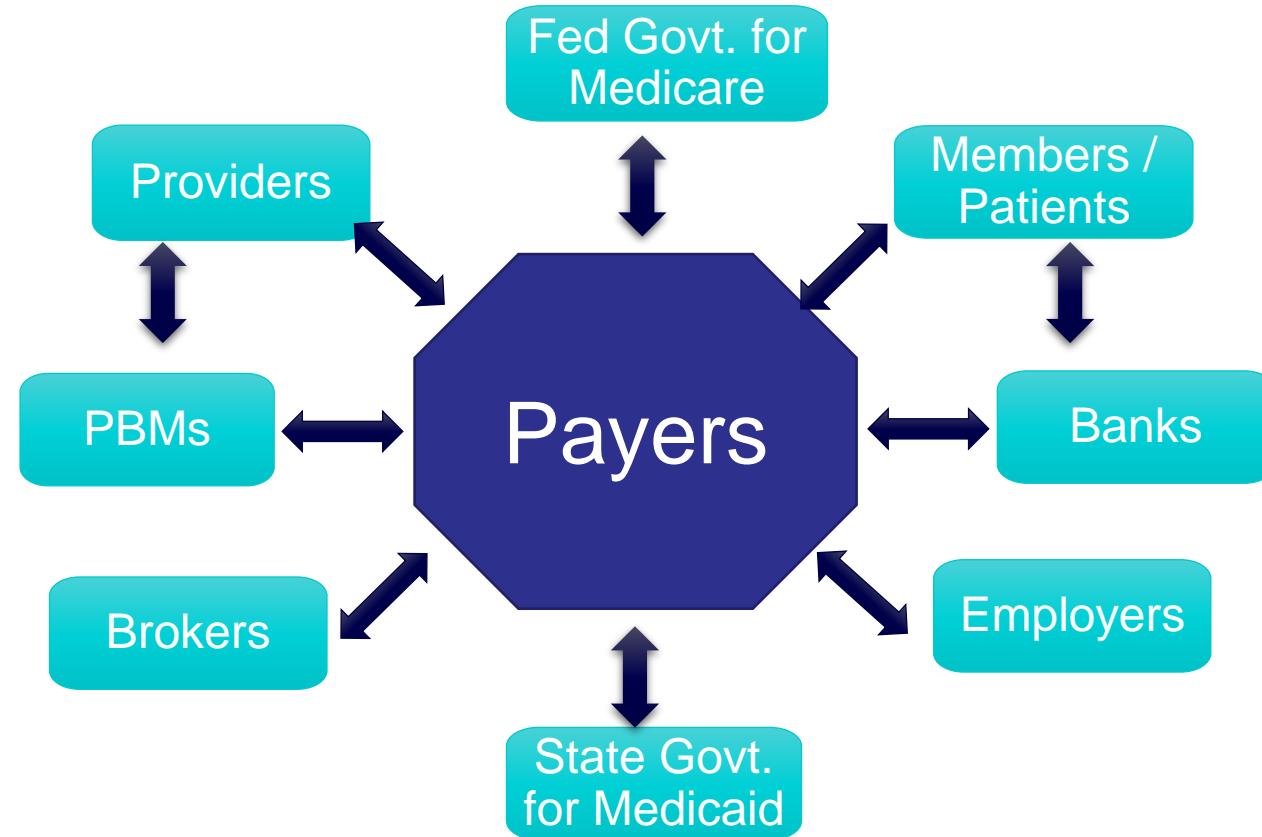
- A condition for which the individual received medical care during the three months immediately prior to the effective date of coverage

How are the entities related ?

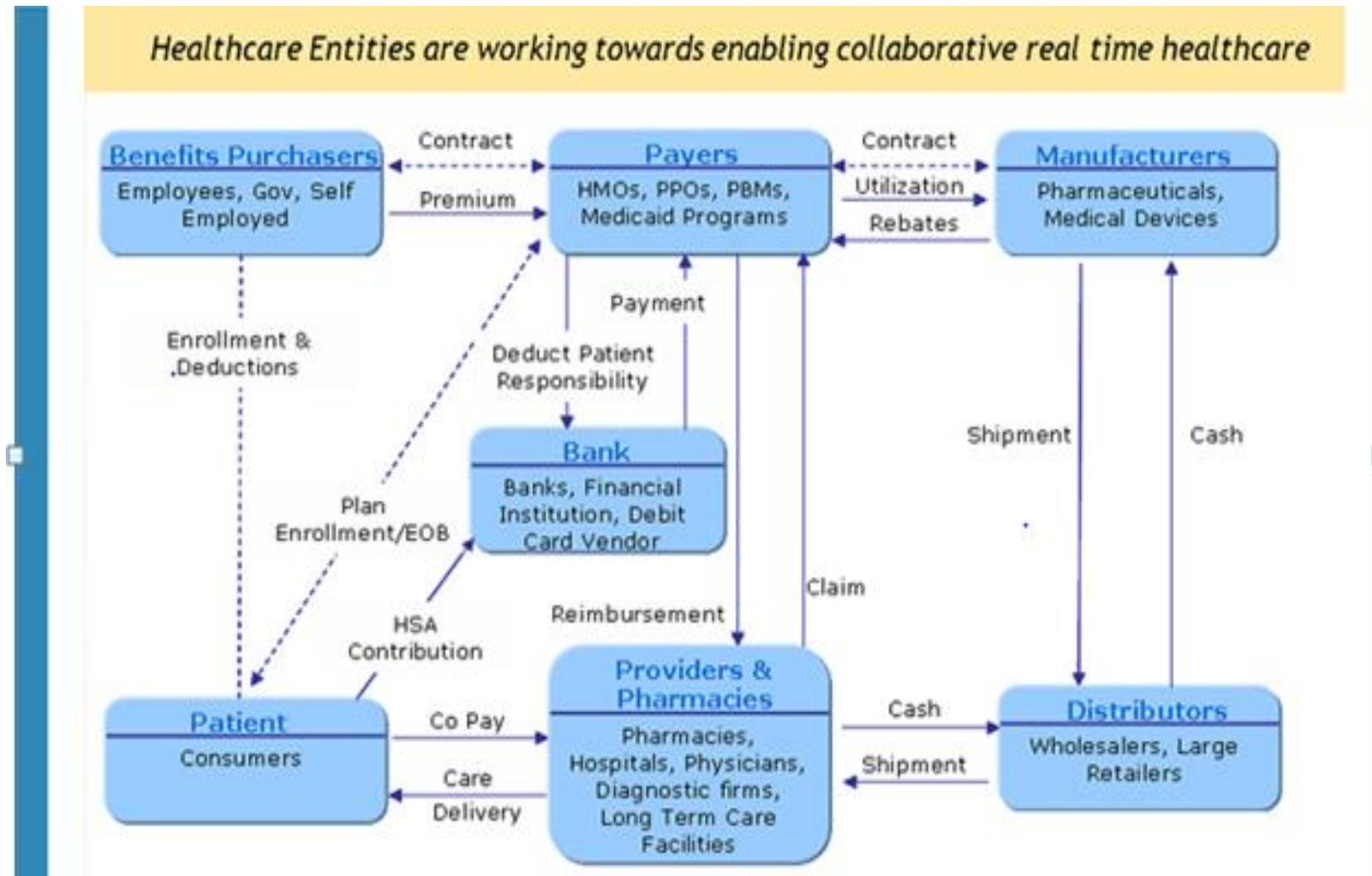


Healthcare Entities

Health Insurance – provides coverage for the financial expenses due to sickness, illness or accidents and they are issued either on individual or group basis.



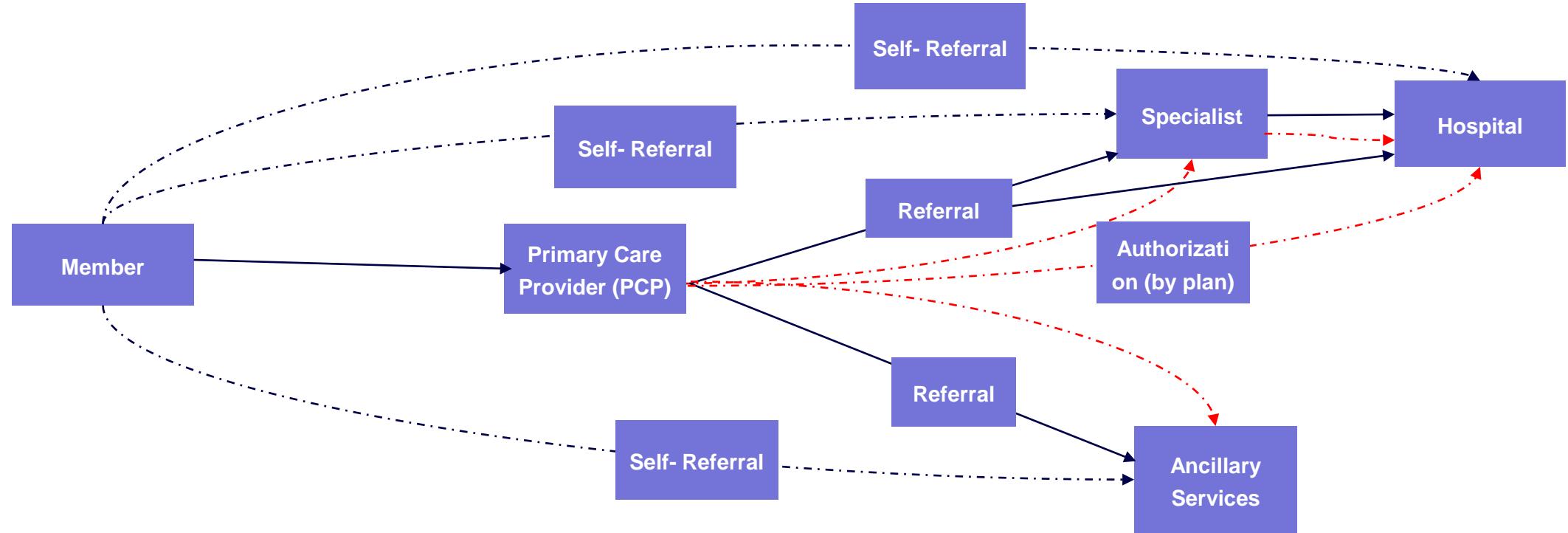
Healthcare Ecosystem



Comparison of Managed Care Entities

Constraint	Indemnity	HMO	PPO	POS
PCP	Not Required	Required	Not Required	Required
Deductible	Required	Not Required	In-network : Not Required Out-of-network: Required	Same as PPO
Out of Network Coverage	Available	Not Available	Available	Available
Referral for Specialist Visit	Not Required	Required	Not Required	Required
Cost (1-5) 5 is max	5	1	4	3
Freedom (1-5) 5 is max	5	1	4	3

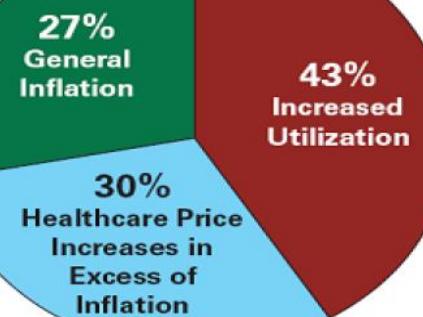
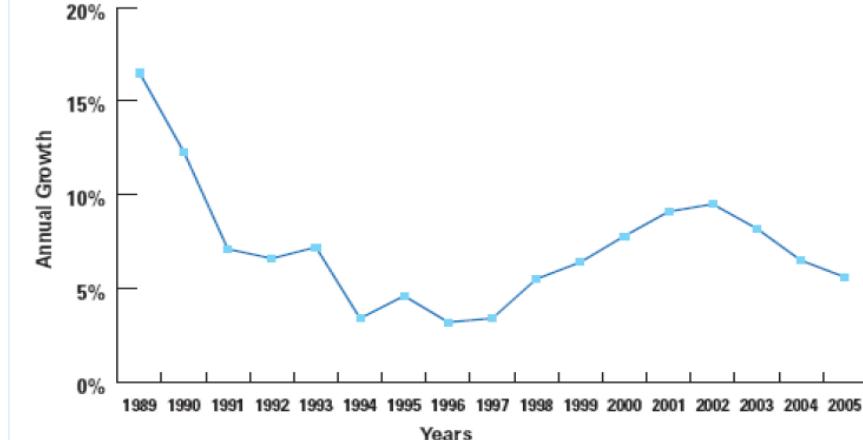
Typical Managed Care Scenario



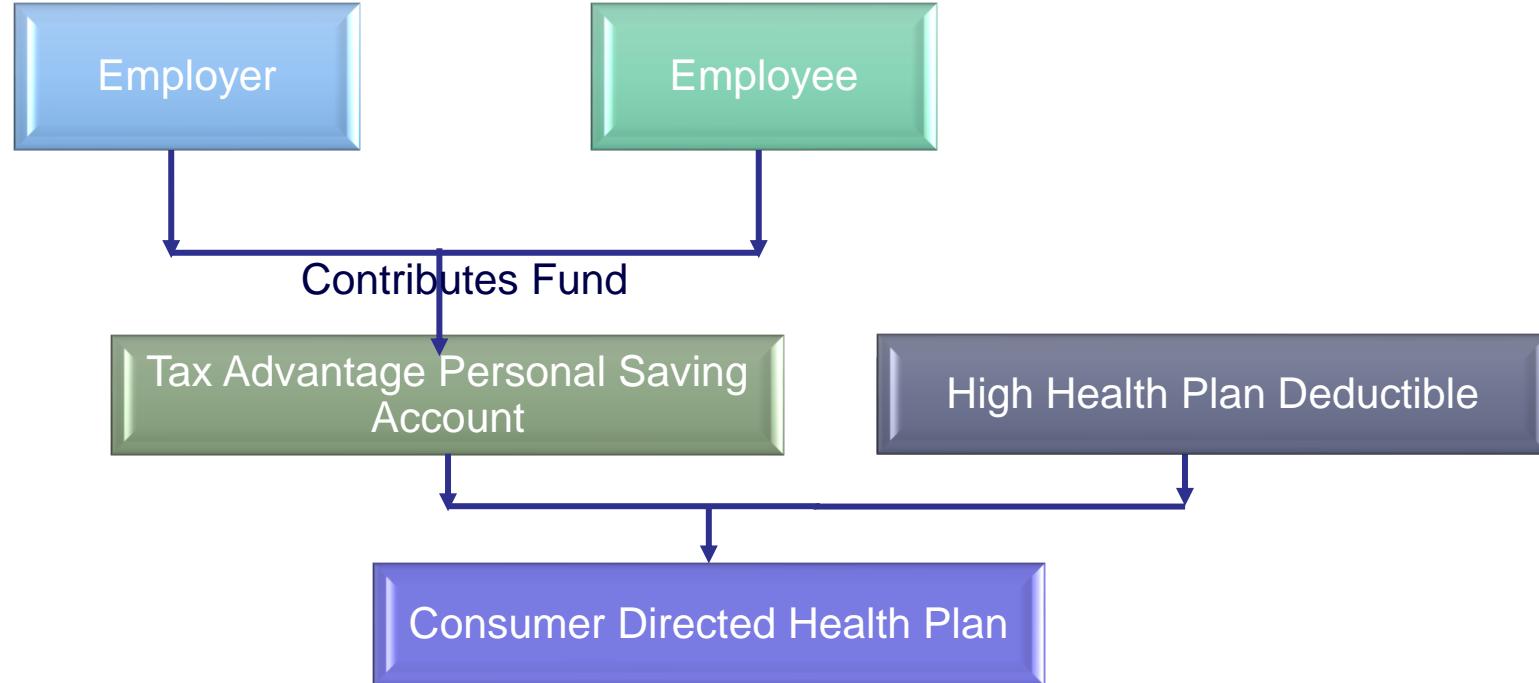
Reason Behind growth of CDHP

- Rise in per capita healthcare spending.
- Premium increases by 13%
- Employers began to offer less restrictive types of plans
- Advancement in internet technology – static to dynamic websites.
- Consumers seeking increased decision making and financial responsibility.

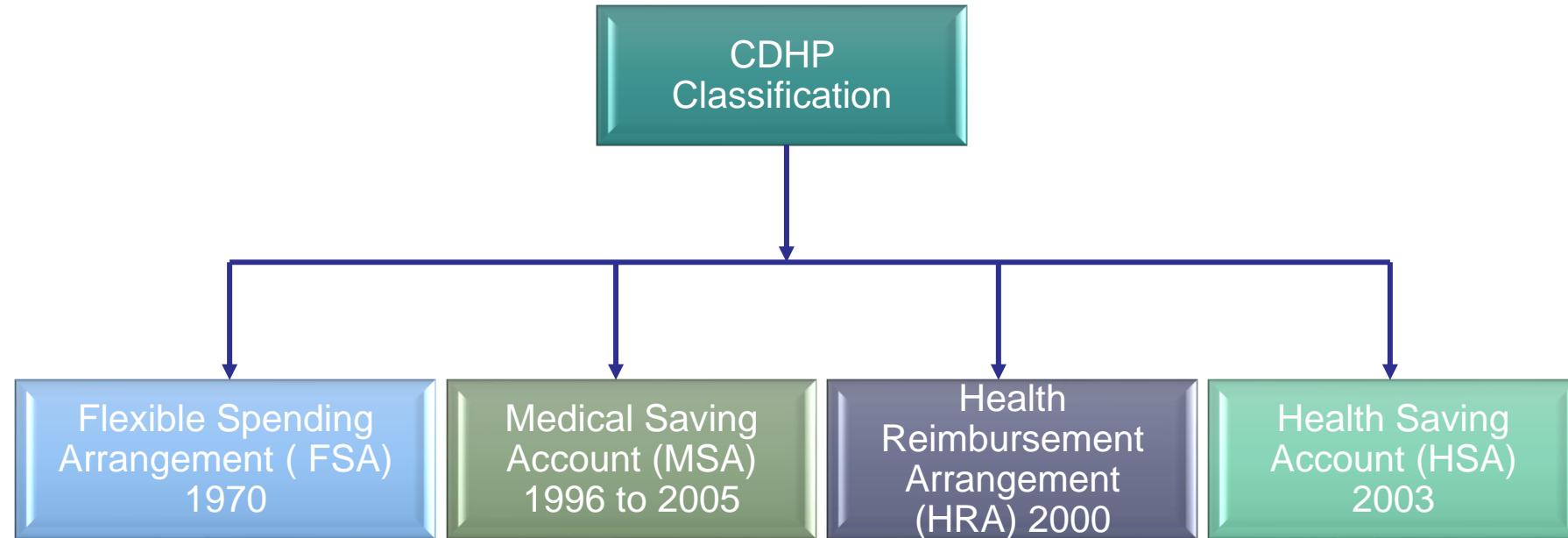
Annual Growth in Private Health Spending Per Capita ■ 1989-2005



Formation of CDHP



Formation of CDHP – Contd..



Comparison among various CDHP Products

Comparison of Various type of CDHP Products				
	FSA	MSA	HRA	HSA
Time of Introduction	Introduced in late 70s	Introduced in 1996 under HIPAA	Introduced in 2000	Introduced in 2003 under Medicare Modernization Act
Established by	Employer	Employer as well as Self Employed Individuals	Employer	Employer as well as Self Employed Individuals
Applicable to	Employer Sponsored People	Small Business or Self Employed People	Employer Sponsored People	Employer Sponsored People & Self Employed
Not Applicable to	Self Employed people	Large or Mid Size Business	Self Employed people	N/A
Fund Contributed by	Employee	Either Employer or Employee Contributes	Employer	Both Employer as well as Employee
Fund use with HDHP	May or may not be used in conjunction with HDHP	Must be used in Conjunction with HDHP	May or may not be used in conjunction with HDHP	Must be used in Conjunction with HDHP
Portability Allowed	No	Yes	No	Yes
Year End Transfer Allowed	No	Yes	Yes	Yes

Provider Credentialing

In-house/Third Party Credentialing Agencies

Providers must submit forms along with supporting docs

Check for licensure, professional liability history, medical education and training, disciplinary history

Sources - State Medical Records, Court Records, National Provider Data Bank (NPDB)

Upon successful credentialing contract is negotiated with the provider

Continuous monitoring once in 2 or 3 years

Health plan re-verifies the credentialing information that is subject to change over time.

Static historical elements, such as medical education and residency, do not need to be re-verified

Credentialing

Re-credentialing

Utilization Review & Authorization

Utilization review (UR)

Evaluation of the medical necessity, appropriateness, and cost-effectiveness of healthcare services and treatment plans for a given patient.

Authorization

Health plan's system of approving payment of benefits for services that satisfy the plan's requirements for coverage.

Medically necessary services

- Consistent with symptoms & diagnosis
- Accordance with standard of good medical practice
- Not solely for the convenience of the member
- Furnished in the least intensive type of medical care setting

Medically appropriate services are diagnostic or treatment measures for which the expected health benefits exceed the expected risks by a margin wide enough to justify the measures.

Framework for Utilization review

- Access requirements
- Frequency of utilization
- Cost and risk of a service
- Total cost
- Level of inappropriate utilization
- Cost of review.

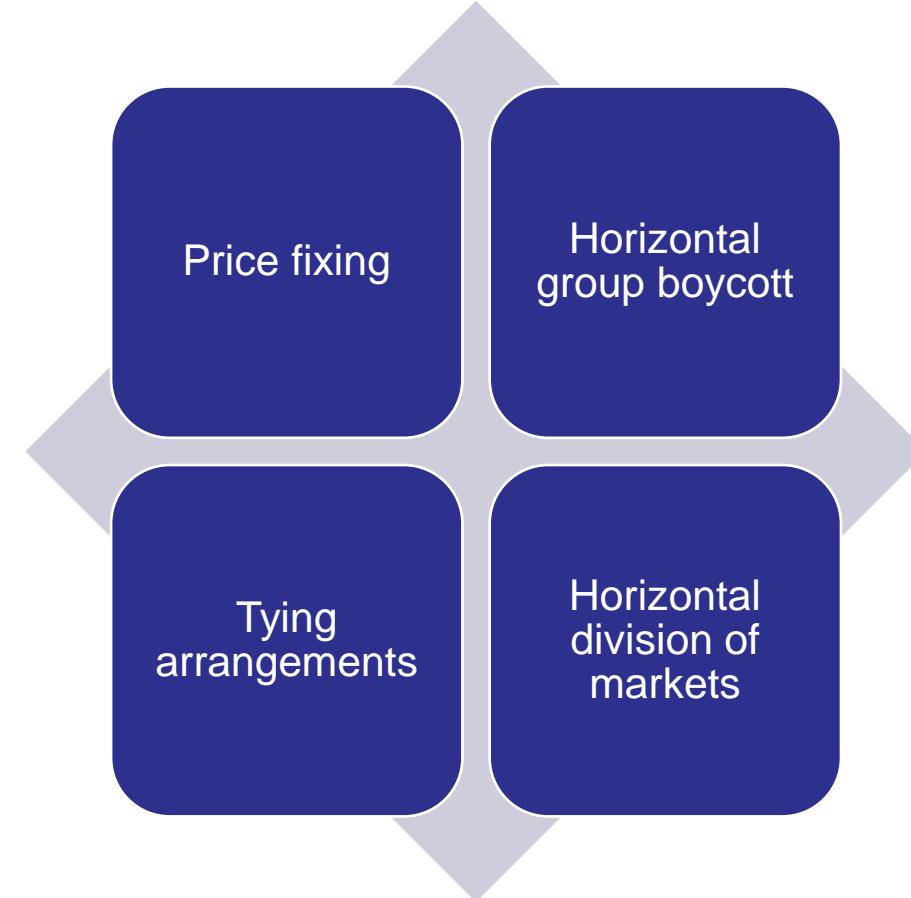
Claims Decision Process

- Adjudicating a claim (determining whether it should be paid and if so how much) can be thought of as satisfying a number of questions about the claim.
- Verifying Member Status - Was the member eligible to receive benefits under the plan at the time services were provided?
- Verifying Provider Status - Was the provider a participant in the plan's network?
- Determining Appropriateness of Treatment Provided - Was the treatment provided medically appropriate and/or medically necessary?
- Verifying Authorization –
 - Was a preauthorization or referral required for the service or treatment?
 - Was a preauthorization or referral given for the service or treatment?
- Verifying That the Service Is Covered by the Plan - Is the service covered under the plan?
- Verifying That the Service Was Actually Provided - Determining the Amount of Benefits to Pay
- What benefits are payable? - Does the member have other health insurance coverage?
- Claims Forms - UB-04(Institutional) and CMS-1500 (Professional)
- Edits- criteria that, if unmet, will prompt further investigation of a claim
- Claim investigation

Federal Laws that affect Healthcare

Legislative Act	Who must Comply	Protected Class	Effect of Legislation on Healthcare
Age Discrimination in Employment Act (ADEA)	Employers with > 20 employees	Employees aged over 40	All active employees irrespective of age must be eligible for the same healthcare coverage and discrimination based on age is prohibited
Title VII of the Civil Rights Act	Employers > 15 employees engaged in interstate commerce	All employees	<p>Prohibits discrimination based on race, color, religion, sex or national origin</p> <p>Pregnancy Discrimination Act (an <i>amendment to this act</i>) requires health plans to provide coverage during childbirth and related medical conditions on the same basis as they provide coverage for other medical conditions</p>
Family and Medical Leave Act FMLA	Employers that have > 50 Employees	Birth/adoption or provide care to seriously ill family members / themselves	Can take up to 12 weeks of unpaid leave in a 12 month period. Employers need to maintain the coverage of group health insurance during this period

Anti- Trust Violation



Federal Anti-Trust legislation

Sherman Antitrust Act (1890)

- Established Competitive Market Mechanisms by prohibiting
 - Monopolizing any part of trade or commerce
 - Engage in contracts, combinations and conspiracies in restraint of trade
 - Applies to all companies engaged in interstate commerce and foreign commerce

Clayton Act (1914)

- Differential Pricing without justification
- Bundling of services

Federal Trade Commission Act (1914)

- Established Federal Trade Commission to enforce Sherman and Clayton Act

McCarran Ferguson Act 1945

- Placed the primary task of regulating health insurance companies on the state

Federal Laws that affect Healthcare

Stark's Law – Ethics in Patient Referral Act (1989)	Healthcare quality improvement Act	ERISA (Employee Retirement Income Security Act)
<ul style="list-style-type: none">• Guards against anti trust activities in the healthcare space• Prohibits physicians from referring patients to another agency in which he has a financial interest• Some exceptions for rural providers	<ul style="list-style-type: none">• Exempts Hospitals, group practices and HMOs from antitrust provisions	<ul style="list-style-type: none">• Regulates entities involved in employee retirement income• Applies to employer sponsored pension plans and to all benefit plans that provide healthcare benefits• ERISA generally take precedence over any state laws that regulate employee welfare benefit plans• Under ERISA, self-funded plans are exempt from paying premium taxes at the state level.• ERISA limits damage awards in lawsuits to the cost of non-authorized treatment. i.e. no compensatory or punitive damages

Federal Laws that affect Healthcare – Contd..

COBRA (Consolidated Omnibus Budget Reconciliation Act, 1986)

- Applies to firms with greater than 20 employees
- Deals with continuation of insurance coverage in the case of a qualifying event
 - Reduced working hours
 - Divorce or death of a covered employee
 - Termination of employment
- Continuation of coverage up to 18 months
- Spouse and Dependents are covered UPTO 36 Months following an employees death or divorce
- Dependent child who ceases to be eligible can continue for UPTO 36 months
- Employees have a right to convert to individual health plan
- The Plan administrator may add the admin fee of 2% to the cost of plan

Gramm-Leach-Bliley (GLB) Act, 1999

- Financial Services Legislation
- Convergence among the traditionally separate components of the financial services industry—banks, securities firms, and insurance companies

Federal Laws that affect Healthcare – Contd..

Gramm-Leach-Bliley (GLB) Act,1999 contd..

- How the financial services industry will be structured in the future and (2) how the financial services industry will be regulated and supervised.
- Describes the rights of customers to protect the privacy of personal financial information
- Notify customers of any sharing of non-public personal financial information with non-affiliated third parties
- Provide the consumers the opportunity to “opt out” of sharing non public personal information

Healthcare Legislations

Federal HMO Act 1973

- Instrumental in defining the structure and operations of HMOs
- Authorized for profit HMOs to contract with Independent Practice Associations (IPA)
- Contracts started with individual physicians for services and compensation
- Paved the way for the growth of HMOs
- Requirements for Federal Qualification
 - Benefits – need to offer a comprehensive benefits package which includes inpatient and outpatient services, unlimited home healthcare benefits, outpatient behavioral healthcare
 - Enrollment – Need to enroll individuals eligible for group coverage without regard to health status
 - Financing – Need to be financially sound and protect against insolvency
 - Quality Assurance – Establish ongoing quality assurance program in line with HCFA
 - Dual choice provision (removed in 1995)
 - Federal funds (removed in 1995)

Health Insurance Portability and Accountability Act

Title I – Insurance Portability

- Individual Coverage Provisions
 - Compulsory provision for individuals who in the last 18 months had group coverage but is now ineligible for either group coverage or Medicare/ Medicaid
 - Issued automatically without a medical examination and without regard to preexisting conditions
- Group Coverage Provisions
 - Preexisting condition treatment/diagnosis should have been received within 6 months prior to enrollment date
 - Preexisting condition exclusion not to exceed 12 months after enrollment date (18 months for late enrollees)
 - Need to reduce the length of preexisting condition based on the creditable coverage
 - Creditable coverage only if the period was not followed by a break in coverage of 63 days or more
 - Waiting period under employee sponsored plan does not constitute a break in coverage
 - Pregnancy cannot be treated as a preexisting condition
 - Guaranteed availability of coverage for small groups – Employees or employee dependents of employee groups with 2 to 50 employees cannot be excluded based on health status
 - Guaranteed Renewability of coverage for all groups

Health Insurance Portability and Accountability Act – Contd..

Title II – Administrative Simplification

- EDI Standards, Privacy and Security Regulations
- Need an individual's written consent to use e-PHI for activities other than treatment, payment or health operations
- Allow patients to access their medical records and request amendment of incorrect or incomplete medical information.
- Allow patients to request that restrictions be placed on the accessibility and use of protected health information.
- Ensure the confidentiality, integrity, and availability of all electronic protected health information (EPHI) the covered entity creates, receives, maintains, or transmits;
- Ensure compliance by its workforce.

Amendment of Title I of HIPAA

Mental Health Parity Act of 1996

- Prohibits group health plans from applying more restrictive annual and lifetime coverage for mental illness than for physical illness.
- Does not require health plans to offer mental health coverage. Instead, it imposes requirements on those plans that do offer mental health benefits

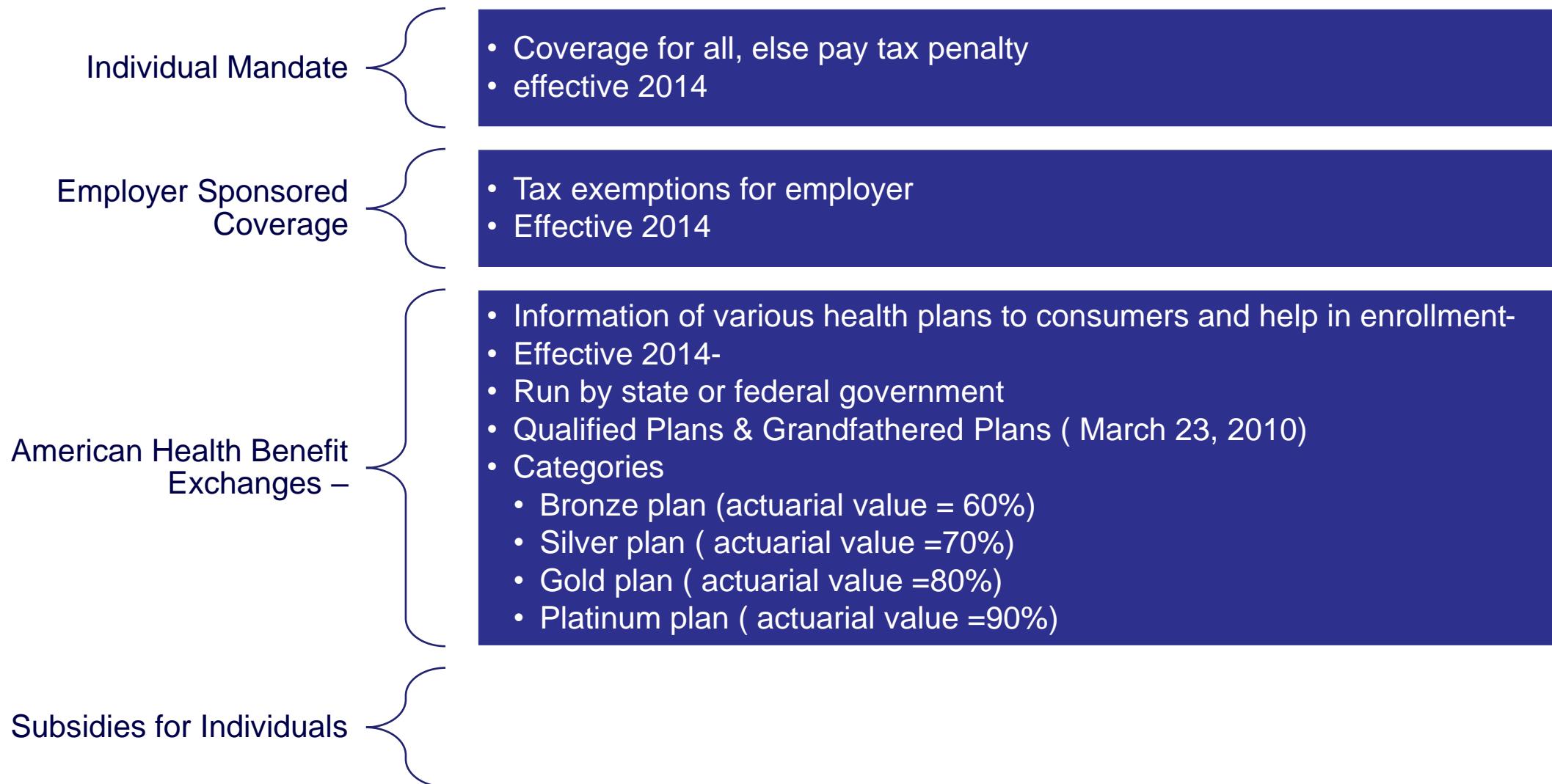
Newborn's and Mothers Health Protection Act of 1996

- Cannot mandate hospital stays be shorter than 48 hrs for normal deliveries or 96 hrs for cesarean birth
- Does not require health plans to offer maternity benefits. Instead, it imposes requirements on those plans that do offer such benefits

Women's Health and Cancer Rights Act

- Requires health plans that offer medical and surgical benefits to provide coverage for reconstructive surgery following the same
- Does not require health plans to offer mastectomy benefits. Instead, it imposes requirements on those plans that do offer such benefits

Affordable Care Act (ACA)-2010



Affordable Care Act (ACA)-- Contd..

Requirements for Health plans	Taxation
<ul style="list-style-type: none">• No Life time limits – effective 2010• No annual limits – effective 2014• Medical Loss ratio (MLR) and rebates - 85%- effective 2011• Guaranteed issue – effective 2014 – without considering individuals current and past medical history• No Pre-existing condition – effective 2010 for children and 2014 for adults• Premium rating – effective 2014- based only on age, geographic area, family size and tobacco use• Guaranteed renewable – effective 2014• Dependent coverage – effective 2010- children upto age 26• Deductibles – effective 2014 – for small group market cannot exceed \$2000 for individuals and \$4000 for family• Rescission – effective 2010 – Insurer cannot rescind coverage except for fraud	<ul style="list-style-type: none">• Tax on High value (Cadillac) health plan – effective 2018- premium greater than \$10,200(individual) or \$27,500(family)• Medicare taxes on high-income taxpayers –effective 2013• Tax on health insurers - 2014 to 2018• Tax on drug (branded) and medical device manufacturers

State Laws

NAIC Health Maintenance Organization Model Act (HMO Model Act)

- Regulates HMO operations in two critical areas: financial responsibility and healthcare delivery.
- Financial Responsibility Requirements
 - COA
 - If the state insurance commissioner finds that an HMO is or is likely to become insolvent, the commissioner can intervene by
 - Monitoring a corrective plan developed by the HMO
 - Reducing the volume of new business the HMO can accept
 - Taking steps to reduce the HMO's expenses
 - Prohibiting the HMO from writing new business for a specified period of time
 - *Administrative supervision*
 - *Receivership*

Government Programs

Medicare

- Federal Program
- Age 65 & Older
- Disabled
- ESRD

Medicaid

- State Program
- Income Based



Medicare & Medicaid:

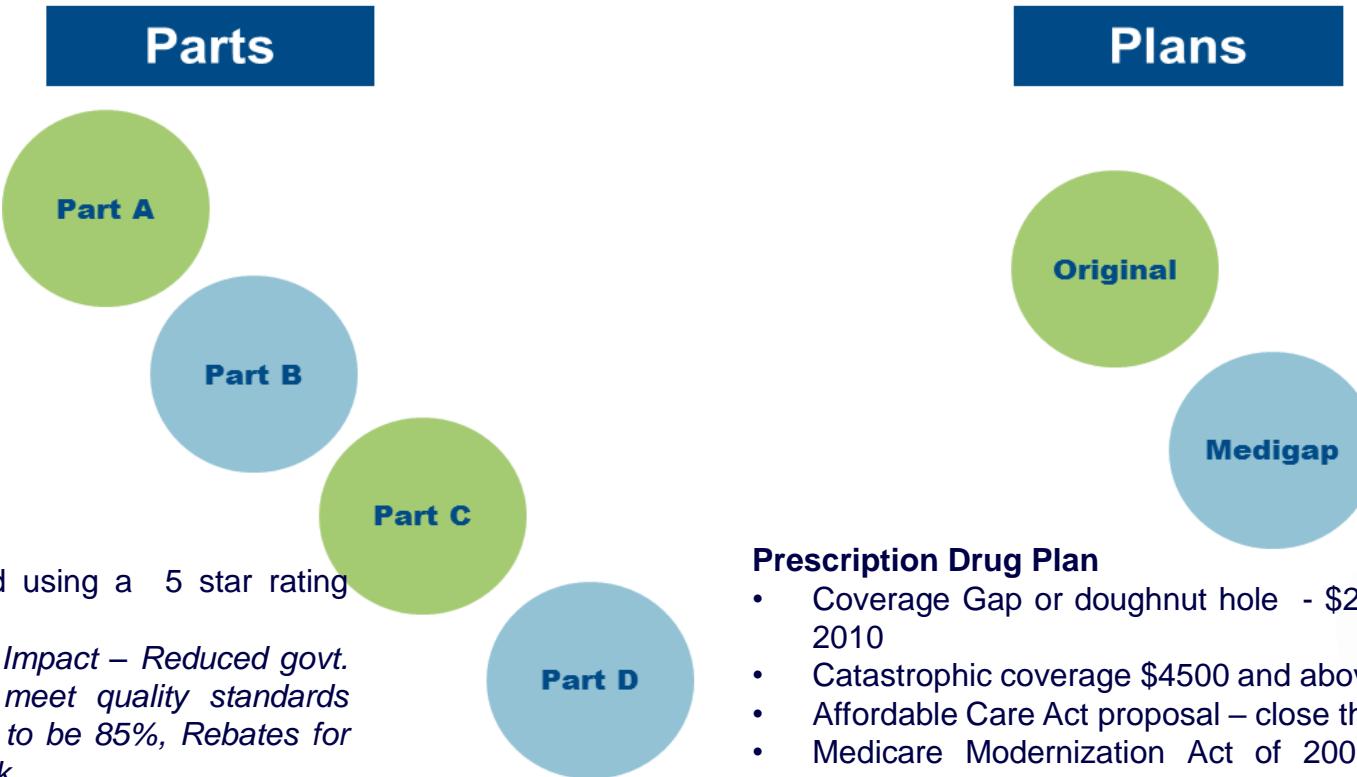
- Federally Funded
- Similar Benefits

Medicare

<i>Medicare Eligible</i>			
Aging	Disabled	Railroad Retired	ESRD
Facts: <ul style="list-style-type: none">Must be 65 years of age or olderMay qualify even if still working	Facts: <ul style="list-style-type: none">Medical condition must last at least 12 monthsUnable to work due to the disability	Facts: <ul style="list-style-type: none">Railroad Retirement Board benefit eligible	Facts: <ul style="list-style-type: none">Individual is renal impairedNeed kidney transplant or regular dialysis to maintain normal function

Medicare – Contd..

Medicare Components



Medicare Advantage

- MA plans are ranked using a 5 star rating system
- Affordable Care Act *Impact* – Reduced govt. funding from 2012, meet quality standards and get bonus, MLR to be 85%, Rebates for bids below benchmark

Prescription Drug Plan

- Coverage Gap or doughnut hole - \$2800 to \$4500 as of 2010
- Catastrophic coverage \$4500 and above
- Affordable Care Act proposal – close the gap by 2020
- Medicare Modernization Act of 2003 - Creation of a voluntary prescription drug benefit coverage for Medicare Part D recipients

Medicare – Contd..

Medicare supplement – reimbursement for deductibles, coinsurance and some other benefit not covered by Medicare

- Medigap policies- sold by State licensed private insurance companies
- Medicare Advantage enrollees do not need (and are not permitted to purchase) Medigap policies
- Medicare SELECT is a Medicare supplement that uses a preferred provider organization (PPO) to supplement Medicare Part B coverage. Medicare SELECT does not apply to Part A benefits.

Medigap Benefits	Medigap Plans Effective June 1, 2010									
	A	B	C	D	F*	G	K	L	M	N
Medicare Part A Coinsurance hospital costs up to an additional 365 days after Medicare benefits are used up	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Medicare Part B Coinsurance or Copayment	✓	✓	✓	✓	✓	✓	50%	75%	✓	✓***
Blood (First 3 Pints)	✓	✓	✓	✓	✓	✓	50%	75%	✓	✓
Part A Hospice Care Coinsurance or Copayment	✓	✓	✓	✓	✓	✓	50%	75%	✓	✓
Skilled Nursing Facility Care Coinsurance			✓	✓	✓	✓	50%	75%	✓	✓
Medicare Part A Deductible		✓	✓	✓	✓	✓	50%	75%	50%	✓
Medicare Part B Deductible			✓		✓					
Medicare Part B Excess Charges					✓	✓				
Foreign Travel Emergency (Up to Plan Limits)			✓	✓	✓	✓			✓	✓
Medicare Preventive Care Part B Coinsurance	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓

Medicaid

<i>Low-Income Eligible Populations</i>			
Children	Pregnant Women	Adults and Elderly	Disabled
Facts: <ul style="list-style-type: none">Most States expand benefits or coverage for childrenInitiatives to find and enroll children in most States	Facts: <ul style="list-style-type: none">Income threshold is extended to 185%Medicaid funds 40% of all births in the U.S.	Facts: <ul style="list-style-type: none">Non-disabled adults living at or below 133% FPLElderly populations at or below 133% FPL (Medicare and Medicaid)	Facts: <ul style="list-style-type: none">Disabled individuals may qualify for both Medicare and MedicaidStates have individual requirements

Medicaid – Contd..

Low-income population and certain aged and disabled individuals – medically needy and categorically needy

Dual Eligible

Spend down – to be eligible for Medicaid

Medicaid recipients could voluntarily enroll in managed care plans

Funding – both state and federal government

Medicaid Health plans

- HMOs and health insuring organizations
- Prepaid inpatient Health Plan (PIHP)
- Prepaid ambulatory health plan (PAHP)
- Health Insuring Organization (HIO)
 - a fiscal intermediary that contracts with a state Medicaid agency
 - The HIO does not provide medical services, but contracts with medical providers on behalf of the Medicaid
- Primary care case manager (PCCM)
 - PCP who contracts directly with the state to provide case management services, such as coordination and delivery of services, to Medicaid patients
 - Most PCCMs receive a case management fee in addition to reimbursement for medical services on a FFS basis

Medicaid – Contd..

States could also make managed care enrollment mandatory for Medicaid recipients through waivers provided under Section 1915(b) and Section 1115 of the Social Security Act. *Section 1915(b)* waivers, called “freedom of choice” waivers

- Assigning a PCCM
- Emphasize preventive measures
- Benefits - Early and periodic screening, diagnostic, and treatment (EPSDT) services for children under 21
- Access to care
 - Enrollment in non rural areas a choice of two managed care plans

Reimbursement for providers- accept the payment provided as payment in full

Expansion populations

- Include individuals who do not meet categorically needy or medically needy criteria and therefore fall outside the traditional Medicaid population

Premium Assistance- State pays for premium and cost sharing with private insurance

Medicaid is always the payor of last resort

Other Government Sponsored Programs

SCHIP assistance is available to any child who meets the following eligibility requirements:

Is under age 18

Is not currently eligible for Medicaid or covered under other health insurance

Resides in a family with income below the greater of 200% of the federal poverty level or 50 percentage points above the state's established eligibility limits

The Federal Employee Health Benefits Program (FEHBP)

Voluntary health insurance program for federal employees, retirees, and their dependents and survivors

Operated by the federal Office of Personnel Management (OPM)

Programs of All-inclusive Care for the Elderly (PACE)

55yrs of age and above

Long term and acute care services at a nursing facility level care

No limits on amount, duration, or scope of service, and requires no deductibles, copayments, or other cost-sharing features

TRICARE

The TRICARE program offers following options to military personnel, retirees(honorably discharged after 20 or more years) and their dependents:

- TRICARE Standard –FFS plan – out of pocket expense highest
- TRICARE Extra – similar to network portion of PPO- reduced FFS
- TRICARE Prime –PCP, no co pay, deductibles, co insurance
 - Retires and their dependents enrolled in Tricare prime are subject to co pay and other cost sharing requirements
 - Active-duty personnel are automatically considered enrolled in TRICARE Prime
- US Family Health Plan – a version of TRICARE Prime
 - Beneficiaries do not receive care from military facilities, TRICARE network providers, or Medicare providers, but rather one of the six former Public Health Service healthcare providers.
- TRICARE Reserve Select
 - a premium-based health plan for certain members of the Reserves and their families who are not eligible for FEHB
- TRICARE for Life
 - Medicare wrap-around coverage for individuals enrolled in Medicare Parts A and B
- TRICARE Dental Program
 - a voluntary traditional, premium-based dental insurance plan. It is free-of-charge for active duty service members and activated reservists.
- TRICARE Pharmacy Program

Treatment thru *Military treatment facilities (MTFs)*

TRICARE is always the payor of last resort

Workers Compensation

State mandated program that provides healthcare benefits for healthcare costs and lost wages due to work related injuries

Both for full time & part time employees

Exclusive Remedy Doctrine – Employees can't sue employers for losses

No deductible & co-insurance

Employers can't deny benefits even if they are not at fault

24 hour coverage
• Worker's compensation + Group health plan + disability plan



Questions?



Thank you



Healthcare Foundations

Utilization Management and Customer Services

Learning Services

Agenda

- Utilization Management
 - Utilization Strategies and techniques
 - Utilization Review and Authorization
-
- Customer Service Overview
 - Appeals
 - Channeling
 - Customer Inquiry



Utilization Management

Utilization Management

What is a
Utilization Management ?

Utilization management (UM) refers to health plan programs that manage the use of medical services so that plan members receive necessary and appropriate care in a cost-effective manner and in an appropriate setting.

Typically it includes new activities or decisions based upon the analysis of a situation.

The goal of UM is for the member to receive the right services at the right time in the right place.

Utilization Management - Contd..



Utilization Management – Contd..

Standard utilization management services include prospective review, concurrent review, retrospective review, pre-certification of hospital stays and discharge planning.

Utilization management involves all the components of a health plan's healthcare delivery system, including primary care, specialty care, and both inpatient and outpatient care in hospitals and other facilities.

It also affects emergency care, pharmaceuticals, and ancillary services (such as X-ray and laboratory work).

A health plan may conduct its own utilization management, or it may contract with an external organization that specialized in UM to perform some or all UM functions

UM Strategies and Techniques

The strategies need to be applied by a health plan depends on its member population.

UM strategies are used either to address the needs of members with existing health condition (**Pre existing Condition**) or to help members at risk of developing condition (**Preventive Care**)

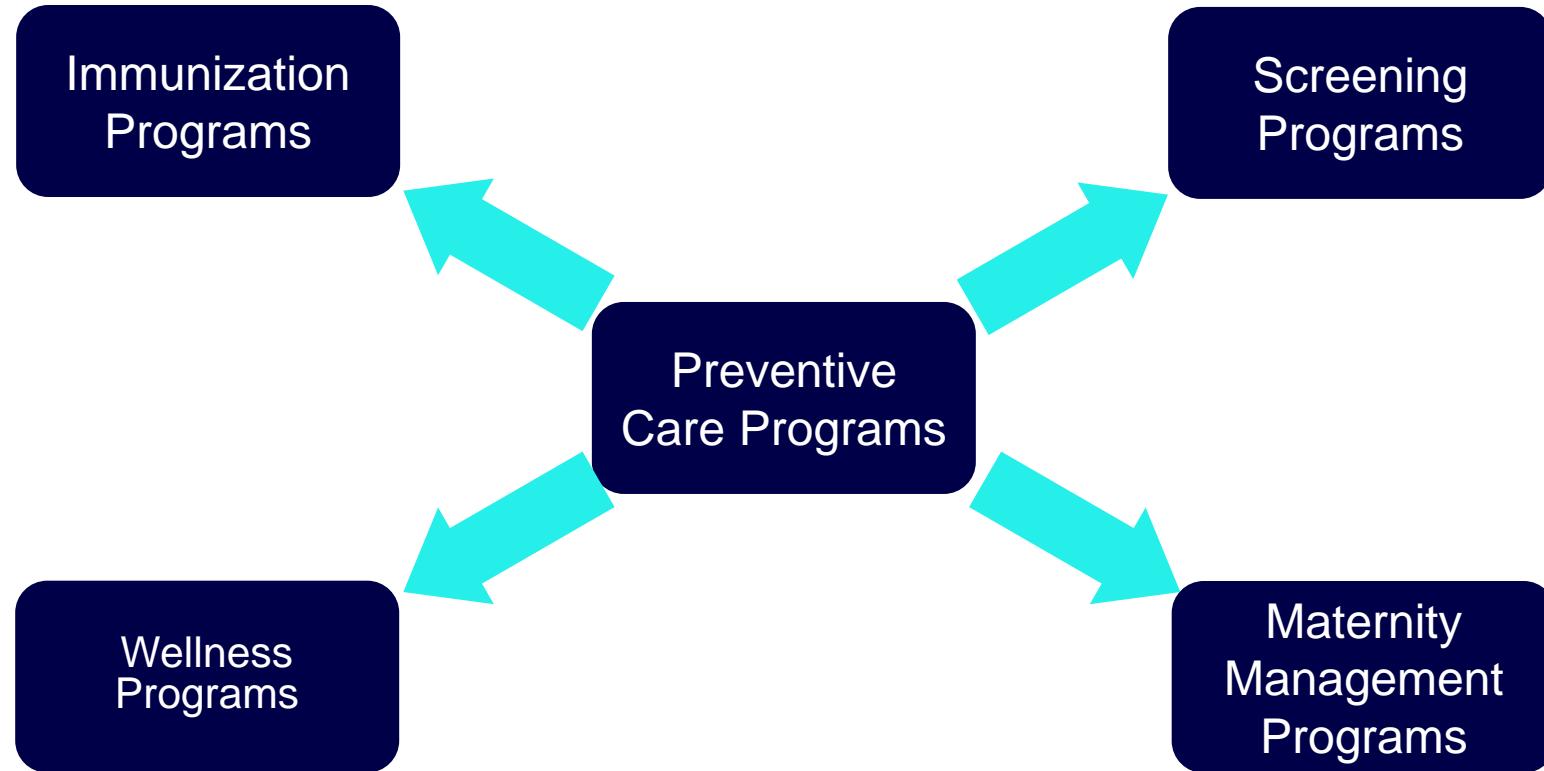
UM Strategies and Techniques - Contd..

Health Risk Assessment (HRA) is a process by which a health plan uses information about a plan member's current health status, personal and family health history, and health-related behaviors to determine the member's likelihood of experiencing specific illnesses or injuries.

By identifying members who are at risk of developing certain health problems and helping them take steps to reduce their risk, the plan can improve health outcomes, reduce the need for complex and extended care, and reduce costs.



UM Strategies and Techniques - Contd..



Utilization Review and Authorization

Utilization Review (UR)

- refers to an evaluation of the medical necessity, appropriateness, and cost-effectiveness of healthcare services and treatment plans for a given patient.

Authorization

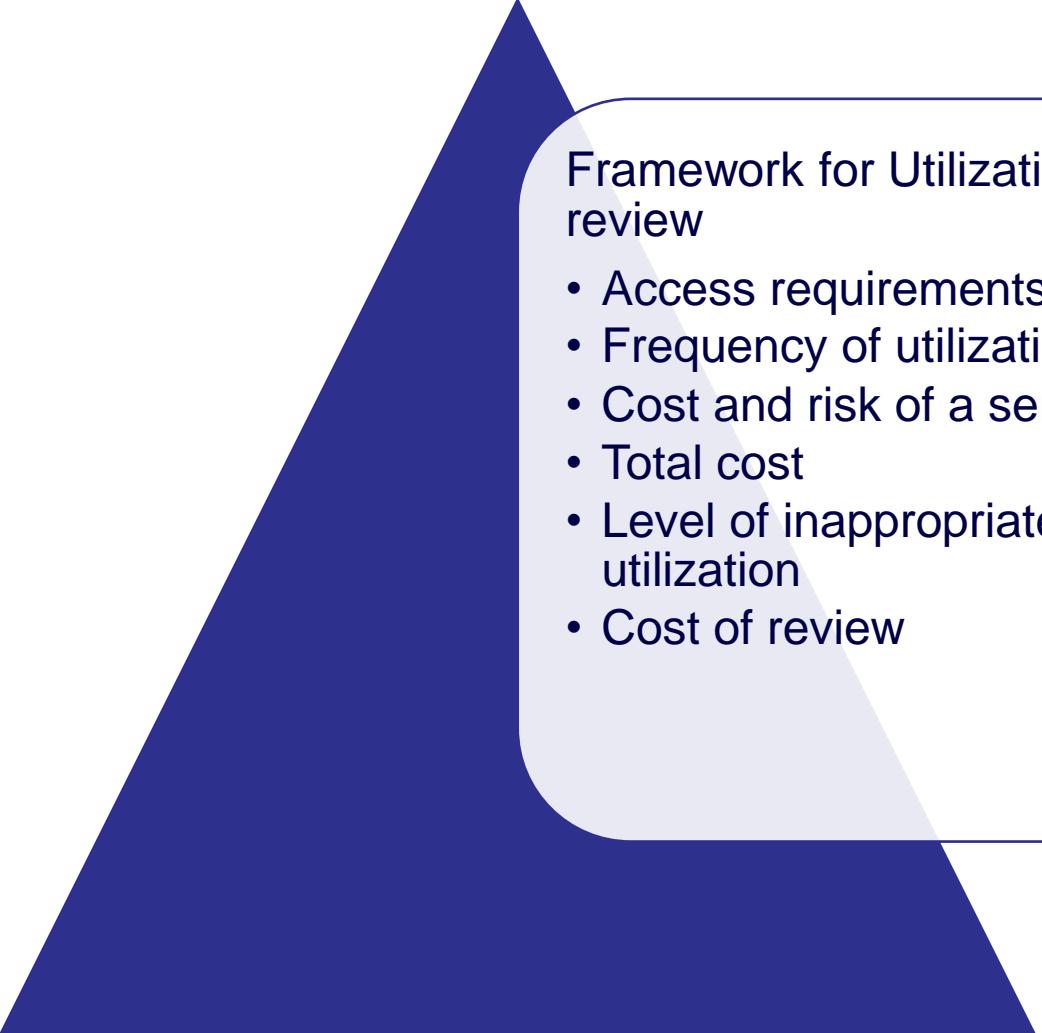
- is a health plan's system of approving payment of benefits for services that satisfy the plan's requirements for coverage.

Medically necessary services

- Consistent with symptoms & diagnosis
- Accordance with standard of good medical practice
- Not solely for the convenience of the member
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Medically appropriate services are diagnostic or treatment measures for which the expected health benefits exceed the expected risks by a margin wide enough to justify the measures.

Utilization Review and Authorization – Contd..



Framework for Utilization review

- Access requirements
- Frequency of utilization
- Cost and risk of a service
- Total cost
- Level of inappropriate utilization
- Cost of review



Customer Service

Overview

Need for Customer Support Application

A health plan receives numerous customer inquiries, complaints, and requests from members, providers, representatives of groups or subgroups, and/or their attorneys, prospective members, and non-members

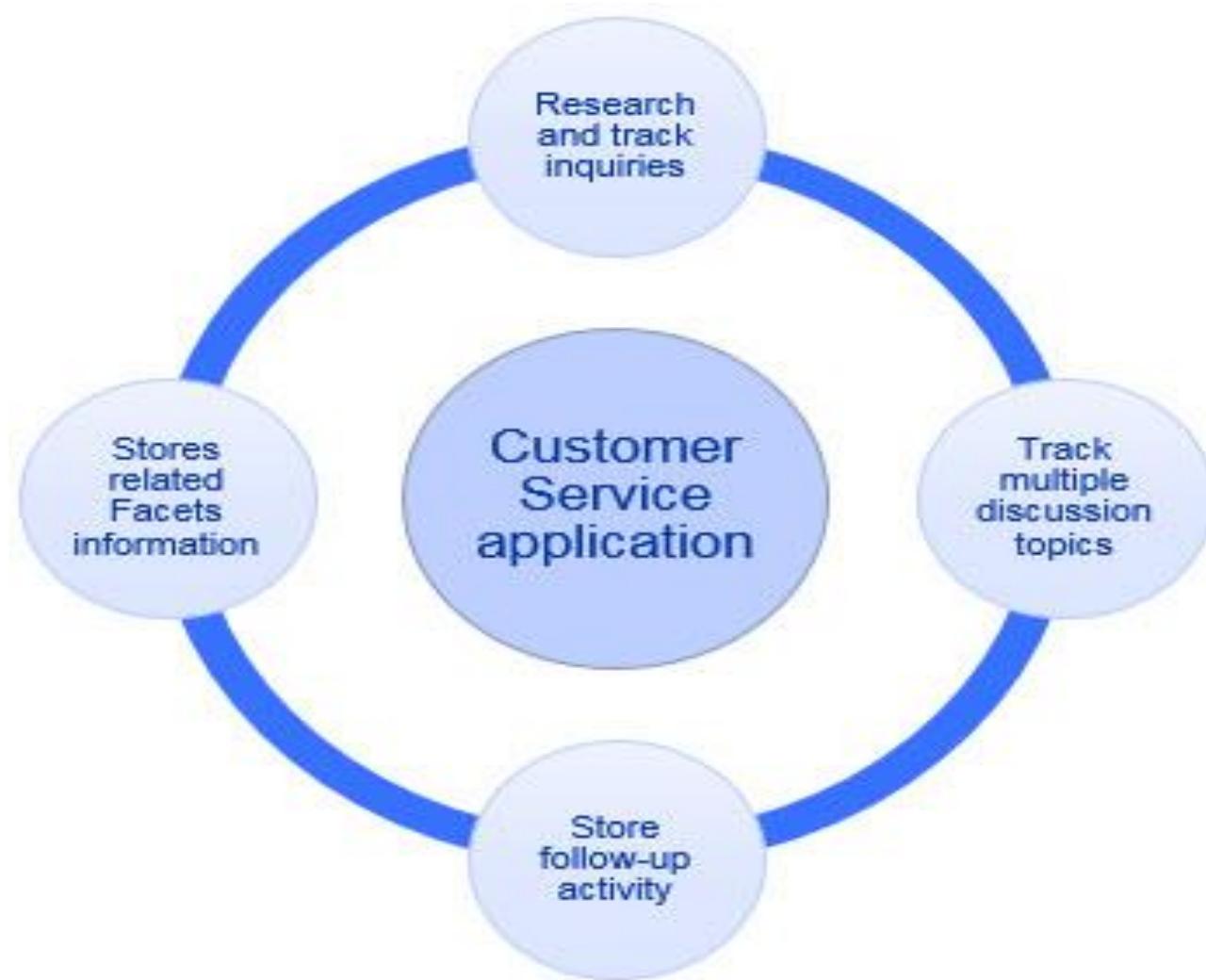
Inquiries may require immediate response, as when a customer is searching for a provider that meets specific criteria or when notifying the health plan of a change of primary care provider

Other inquiries, such as when a customer is registering a complaint and initiating an appeal, may require the representative to enter a record of the activity.

Let's the user store information about the specific follow-up activities related to the call.

Provides other information stored in Facets, like the status of a claim or information regarding a pre-authorization

Overview - Contd..



Facets Customer Service Functionality

- Customer Service Application Group contains the applications that are used to handle the inquiries
- The customer service functionality can be divided as
 - Appeals Processing
 - Channeling
 - Customer Service Inquiry
- Facets contains a Customer Support (Customer Service) Dashboard that brings all the necessary information to the Customer Service Rep without the need for extensions



Customer Service Inquiry

Customer Service Inquiry

A customer service inquiry is usually initiated by the customer or the customer's representative

The purpose of the inquiry might be to request information about plan benefits, to change member or address information, to select a new PCP, or to register a complaint

The customer service representative can record the customer's member ID, the reason for the inquiry, and any other relevant details in the Customer Service application

Depending on the request, the customer service representative can complete the inquiry, pend it for follow up activity, or route it to another user or group

Types of Customer Service Inquiry

Updating Member Information

Confirming Benefits

Requesting ID Cards

Initiating an Appeal



Appeals Processing

Know the Term

Appeal

An appeal is a complaint regarding any aspect of a plan's health care services.

Some of the issues that might provoke an appeal include

- access to services
- plan provision or coverage disputes
- denial of services due to prospective and ongoing utilization management and continuity of care issues.

Grievance

A grievance is a complaint regarding services that were rendered or not rendered within the member's plan.

Some of the issues that might provoke a grievance include

- delay in obtaining an appointment, long wait at appointment time, physician behavior, inability to obtain a service
- coverage disputes, such as denial of a claim or service and disputes over medical necessity
- underwriting disputes, such as refusal to insure or delays in issuing coverage
- marketing and sales disputes, such as failure to respond to enrollee request

Appeal



An appeal or grievance can be initiated by a member, a member's representative, or a provider



Once the appeal has been initiated, the health plan designates an appeal reviewer to review the case and make a decision regarding that appeal



While there is a distinction between an appeal and a grievance, both types of complaints are handled through the same appeals procedures in Facets

Appeal – Contd..



The Customer Service Representative tracks and reports information pertaining to an appeal in the Appeals application



Customer service representatives can also enter information about the persons who are reviewing the appeal, decisions reached by the reviewers, and any other activities associated with the appeal



It is important to note that all of these processes are mandated by the Centers for Medicare and Medicaid Services (CMS) and various state laws.

Appeals Contact and Appeals Reviewer



Appeals Contact

- The individual who is to be contacted or notified of a decision on behalf of the member
- The primary contact record is established in the Appeals Contact application



Appeals Reviewer

- The individual assigned by the health plan to review the member's appeal and make a decision regarding that appeal.
- The appeals reviewer record is established in the Appeals Reviewer application

Prerequisite

- Contact and Appeals Reviewer records must be established in Facets prior to being linked to an appeal
- Without this info, the appeal can be started and then saved and pended

Types of Appeal Processing

Standard Appeal

- Health plan notifies member/ the member's covering provider of its decision in writing
- Reviewer must provide the clinical review criteria that was used to make the determination

Expedited Appeal

- In the event that the time frame and standard review procedures for standard appeals would seriously jeopardize the life or health of the member, or would jeopardize the member's ability to regain maximum function, the appeals process may be expedited
- Communications between the health plan and the member or provider happens by telephone, facsimile, or the most expeditious method available
- If notification was not in writing, written confirmation should follow as soon as possible
- After receiving a request for an expedited review, the health plan should provide reasonable and timely access to an appeals reviewer who can perform the expedited review

Levels of Appeal

There can be up to six levels of appeal logged in the Appeals application.

First Level Review	The member, member's representative, or provider are entitled to submit documentation to support their position. After the First Level of Review, litigation or Alternate Dispute Resolution (ADR) is sometimes an alternate choice
Second Level Review	If an adverse determination is made at the First level, the decision may be appealed. The member, member's representative, or provider is entitled to appear at the Second level review, in addition to providing documentation
Third Level Review	In some cases, it is possible to appeal the adverse decision of the Second level
Fourth Level Review	In some cases, it is possible to appeal the adverse decision of the Third level
Fifth Level Review	To comply with Medicare's standard six appeals levels, it is possible to appeal the adverse decision of the Fourth level
Sixth Level Review	To comply with Medicare's standard six appeals levels, it is possible to appeal the adverse decision of the Fifth level



Channeling

Channeling

Channeling is the process where a health plan finds the providers or facilities that match the specified criteria for a customer who needs the information

The customer service representative can define a customer's requirements, search the Facets database, and find one or more providers or facilities for the customer using the Channeling application

Details about the provider or facility, such as affiliations, number of beds, or office hours, can also be provided to assist the customer in selecting a provider



Thank you

Appendix

Customer Service Application

- On opening, the application lands on “Start a new call” tab.
- Contact Info is of the person who is on the call.
- Customer Info is of the person whose details are being discussed.
- On clicking “Next”, Verification page pops up. Caller is required to verify at least 2 of the data.
- On completing verification, it points to General Task Page.

Customer Service Application – Contd..

- Each task page includes fields in which the user can enter inquiry information and notes regarding a Customer Service task
- The **Subject** and **Category** fields are configurable in the CS Subject/Category Configuration application in Application Support.
- The **Click Notes** area provides additional data about a specific task, such as eligibility, deductibles, or benefits summary.
- Click notes are configurable using the CS List Configuration application found in the Application Support application group.

Customer Service Application – Contd..

- Following member related data adds/changes can be done from CS application
 - Address Add or Address change
 - PCP Add or PCP Change
- All other data can be only viewed and not changed.
- In one call, multiple inquiries can be recorded and each one is called **Tasks**
- After all the details are recorded, status is updated for each task and the call be saved by clicking “End Call”

Appeals - State Requirement

- Regulated by both Federal and State laws (may vary from state to state)
 - Most States require that credentials of the reviewers must be documented and that reviewers must not be involved in the initial determination
 - Some states require committees that are external to the Health Plan
 - All states also require adherence to the Privacy Act Provisions
- Finally, states usually require some type of register that reports the following information:
 - the Number of Appeals
 - the Date Received, Dates of Notification and Date Resolved
 - Reasons for the appeal
 - Resolution of each level of appeal
 - Name of the covered individual
 - Name of the Provider

Appeals Application

- To create a new appeal record, complete the Member page by providing Subscriber Id, Suffix
- Check the Level , Primary User and Status of the Appeal.
- Fill the Category, Type, Sub-Type Description and Summary details in the Appeal Page
- From this page can navigate to Linked Records Page, Level Details, add Providers and view Appeal Reviews details.
- Level Indicative page has the User details and decision update on the appeal, can view the status History of the Appeal.
- The Level details will have the summary captured
- Contacts Page will have the details of Member's / Provider's representative to be reached

Appeals Application – Contd..

Key Tables :

CMC_APAP_APPEALS	Core table for Appeals
CMC_APAL_ADMIN_LOG	Log table for administrative/ Follow up activities
CMC_APCT_CONTACTS	Will hold Contact information of Appeal Representatives

Channeling Application

Key Tables :

CMC_CHCH_CHANNEL



Healthcare Foundations

Capitation, Commissions

Learning Services

Agenda

- Capitation
- Commissions



Capitation

Capitation

Capitation is a payment arrangement for Healthcare service providers such as physicians, physician assistants or nurse practitioners.

It pays a physician or group of physicians a set amount for each enrolled person assigned to them, per period of time, whether or not that person seeks care.

Most commonly, a capitated provider is paid on a **per member per month (PMPM)** basis.

Capitation - Types

Primary Capitation

- a relationship between a Managed Care Organization(MCO) and Primary Care Physician(PCP), in which the PCP is paid directly by the MCO for those enrolled members who have selected the physician as their provider.

Secondary Capitation

- a relationship arranged by the MCO between a PCP and a secondary or specialist provider such as an X-ray facility or ancillary facility such as a durable medical equipment supplier is also paid capitation based on that PCP's enrolled membership

Global Capitation

- a relationship based on a provider who provides services and is reimbursed per-member per month (PMPM) for the entire network population

Capitation Care

Providers who work under such plans focus on preventive health care, as there is a greater financial reward in the prevention of illness than in the treatment of ill.

Such plans divert providers from the use of expensive treatment options.

Most capitation payment plans for primary care service includes

- Preventive, diagnostic and treatment services
- Injections, immunizations, medications
- Outpatient lab tests
- Health Education and Counseling services
- Routine Vision and Hearing screening

Capitation - Risk Sharing

Under Fee For Service, a provider assumes no risk. If insureds need more services than expected, the provider delivers them and is paid for them. Under capitation, providers do bear risk.

If members need few or no services, a provider will have to do little for the capitation payment. But if the member need a lot of care, provider will have to deliver many services and will not be paid any more.

This risk-sharing gives capitated providers a strong **incentive** to avoid **unnecessary services** and control costs.

Promotes healthcare quality as well, because physicians also have a strong incentive to promote prevention and wellness



Commission

Commissions

Health insurance brokers are paid commissions from health insurance companies.

Why ?

- The Brokers guide the employer through the process of selecting the health insurance options for the employees.
- They provide quotes, information about various plans and enrollment assistance at no direct costs. The cost for the brokers are paid by the Insurance companies as commission.
- The commissions are paid come out of the monthly premium the member/employer pay for the health insurance

Commissions – Contd..

The Affordable Care Act requires that the insurance companies spend at least 80 percent of the money from the health insurance premiums on health care costs.

The remaining 20 percent can be spent on administrative costs, marketing and other expenses, like broker commissions.

Most insurers pay brokers a set percentage of premium paid, however some pay a flat fee per policy holder.

Ex: A Insurance company might pay a broker \$10 per new enrollment and \$6 for each renewal.



Thank you



Healthcare Foundations

Claims

Learning Services

Agenda

Claims Operations

- Indicate three key uses of claim data by payers
- Identify three standard code sets

Payment/Denial Explanations

Identify correct claim form based on provider type and service billed

- Professional Claims (1500)
- Facility Claims (UB 04)
- Describe the purpose of remittance advice and explanation of benefit statements

Claims Administration

What is a Claim ?

A **claim** is a request to an insurer or health plan for payment of benefits.

- Billed by provider on behalf of member
- The person or entity submitting a claim is called the **claimant**; this may be an insured, but in health coverage it is most often a provider.
- **Claims administration** or **claims processing** is the receiving, reviewing, adjudicating, and paying of claims.
- In a health plan, the claims function varies by plan type and provider compensation arrangement

- The claim links every facet of the healthcare community.



Claims Operations

The claim provides important data to the payer.

Disease management

Reporting and Analysis

Provider Reimbursement

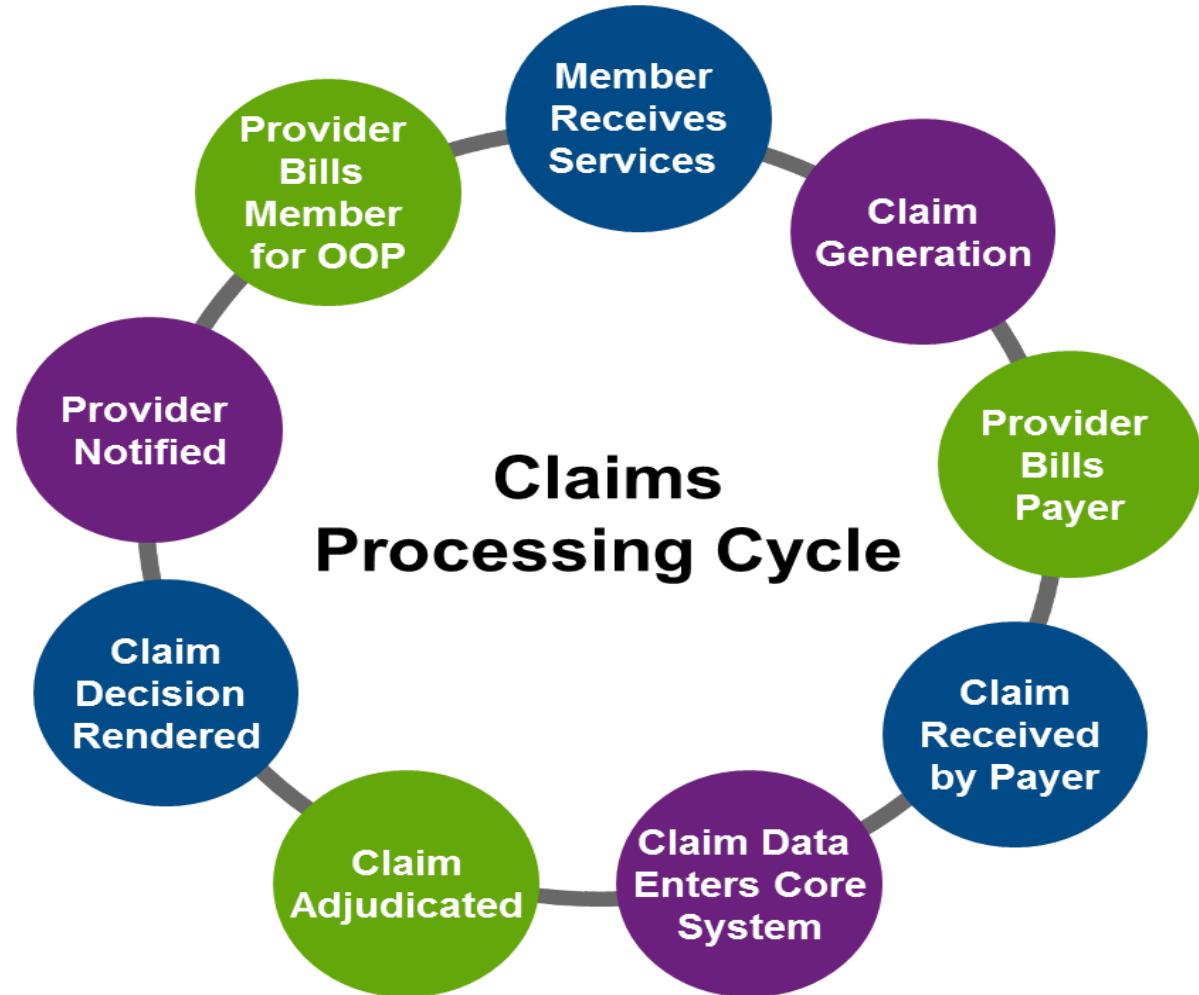
Premium Determination

Benefit Determination

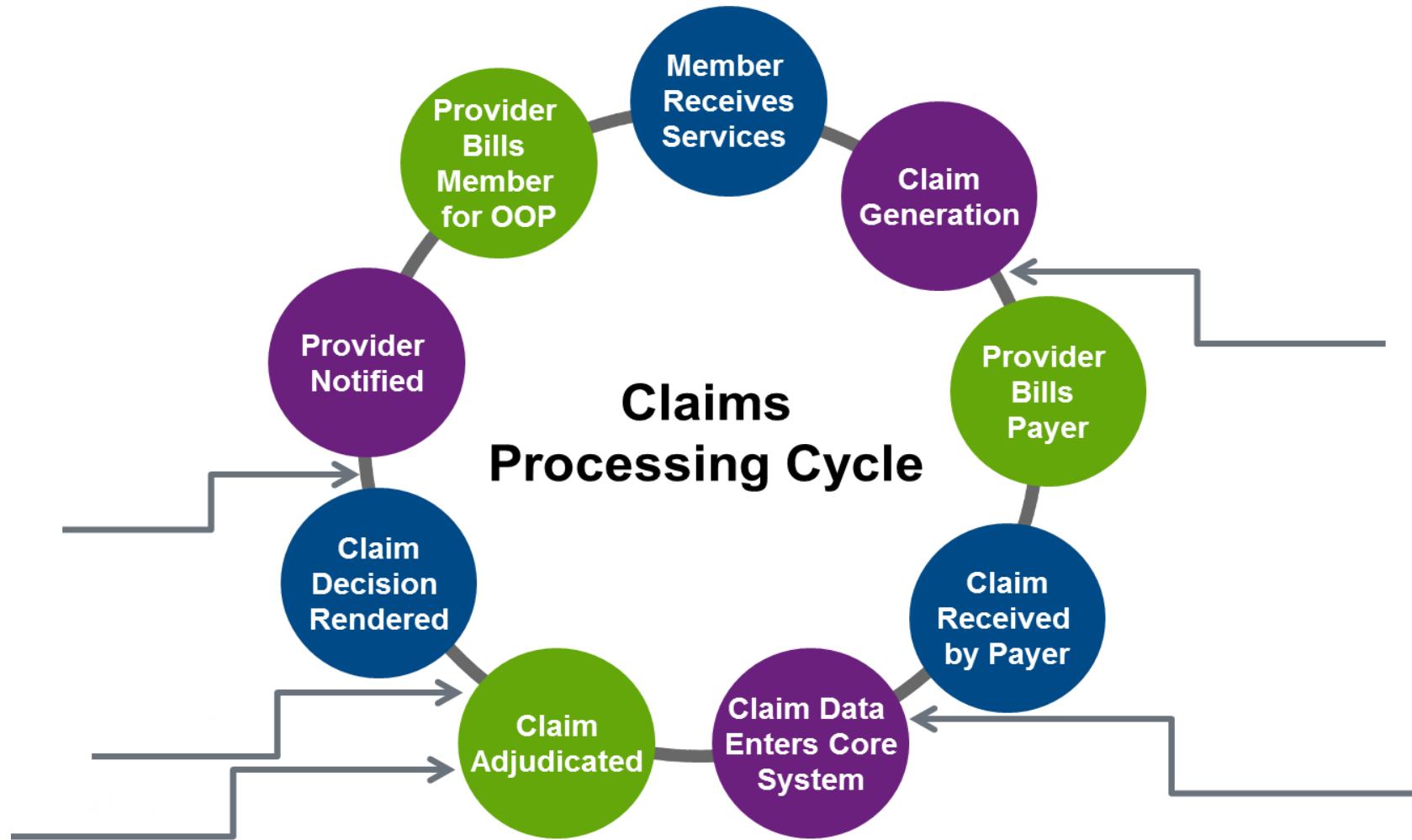
HEALTH INSURANCE CLAIM FORM
APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

1. MEDICARE MEDICAID TRICARE CHAMPVA GROUP HEALTH PLAN FECA
(Check one) (Check one) (Check one) (Check one) (Check one) (Check one)
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) 3. PATIENT'S BIRTH DATE
MM DD YY 4. SEX M F
5. PATIENT'S ADDRESS (No., Street) 6. PATIENT RELATIONSHIP TO INSURED
Spouse Child Other
CITY STATE CITY STATE
ZIP CODE TELEPHONE (include Area Code) CITY STATE
ZIP CODE TELEPHONE (include Area Code)
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) 10. IS PATIENT'S CONDITION RELATED TO:
a. OTHER INSURED'S POLICY OR GROUP NUMBER a. EMPLOYMENT? (Current or Previous)
b. RESERVED FOR NUCC USE b. AUTO ACCIDENT? PLACE (State)
c. RESERVED FOR NUCC USE c. OTHER ACCIDENT? d. YES NO
d. INSURANCE PLAN NAME OR PROGRAM NAME e. YES NO
10. CLAIM CODES (Designated by NUCC)
11. INSURED'S POLICY GROUP OR FECA NUMBER
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize the release of any information or other information necessary
to process this claim. I also request payment of government benefits due to myself or to the party who accepts assignment
below.
13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize
payment of medical benefits to the undersigned physician or supplier for
services described below.
14. DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (MM DD YY) 15. OTHER DATE
MM DD YY 16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION
MM DD YY FROM MM DD YY TO MM DD YY
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a. NPI
17b. NPI
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES
MM DD YY FROM MM DD YY TO MM DD YY
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. Please list all services listed below (H&E) ICD-9-CM
a. b. c. d. e. f. g. h. i. j. k. l.
24. a. DATES OF SERVICE b. PLACE OF SERVICE c. D. PROCEDURES, SERVICES, OR SUPPLIES
From MM DD YY To MM DD YY EXP (List unusual circumstances if applicable) e. MODIFIER
f. CHARGES g. DAYS ON UNITS h. RATE PER UNIT i. ICD-CM j. RENDERING PROVIDER ID #
1 2 3 4 5 6
25. FEDERAL TAX ID NUMBER 26. PATIENT'S ACCOUNT NO. 27. ACCEPT ASSIGNMENT
SIGN ER MM DD YY MM DD YY MM DD YY
28. TOTAL CHARGE 29. AMOUNT PAID 30. Prior to NUCC Use
\$ \$ \$
31. SIGNATURE OF PHYSICIAN OR SUPPLIER
INCLUDING DEGREES OR CREDENTIALS
(I certify that the statements on this reference
apply to this bill and am made a part thereto.) 32. SERVICE FACILITY LOCATION INFORMATION
33. BILLING PROVIDER INFO & PH # ()
SIGNED DATE S. NPI PLEASE PRINT OR TYPE
NUCC Instruction Manual available at: www.nucc.org APPROVED OMB-0938-1197 FORM 1500 (02-12)

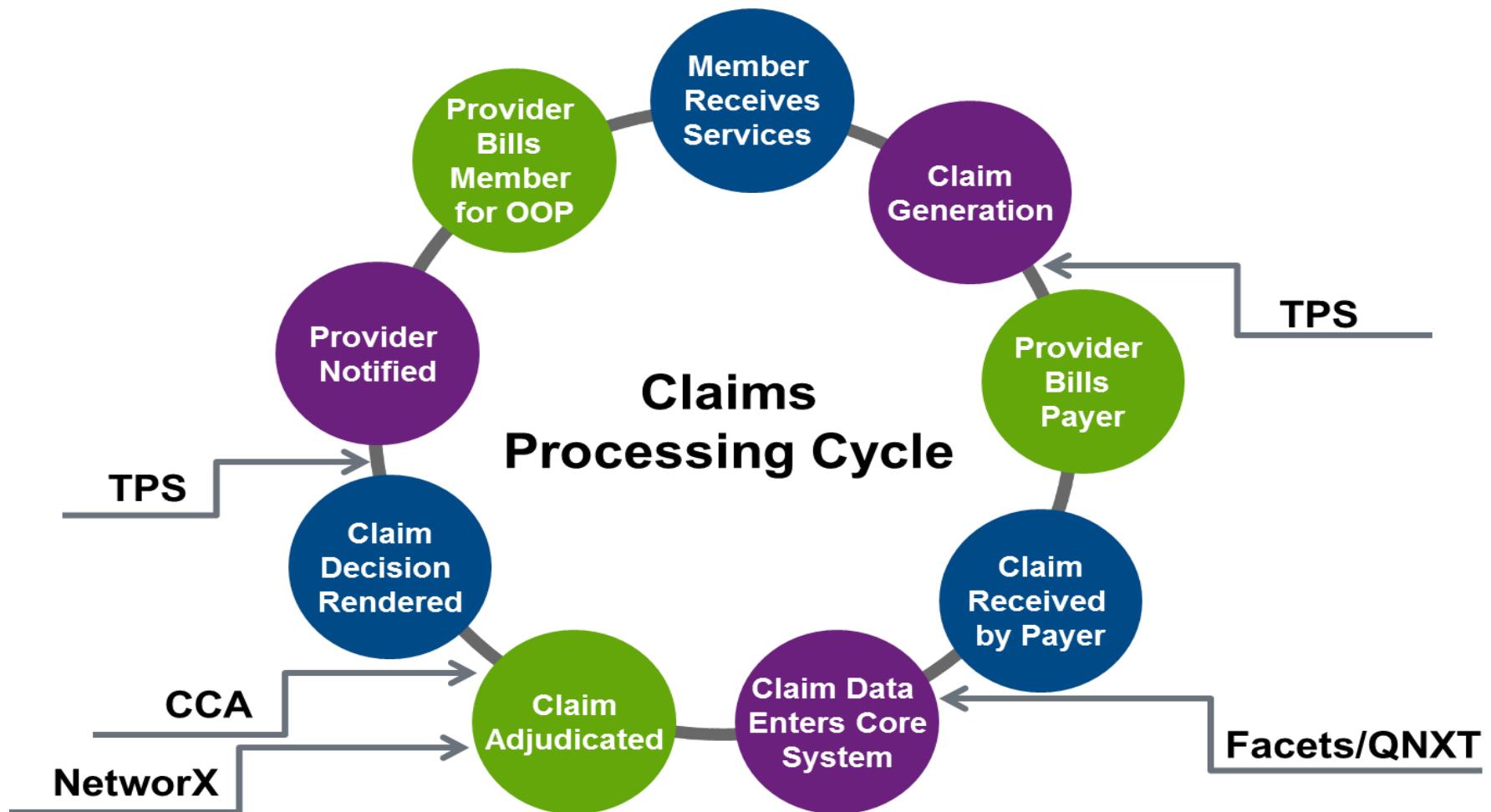
Claims Processing Cycle



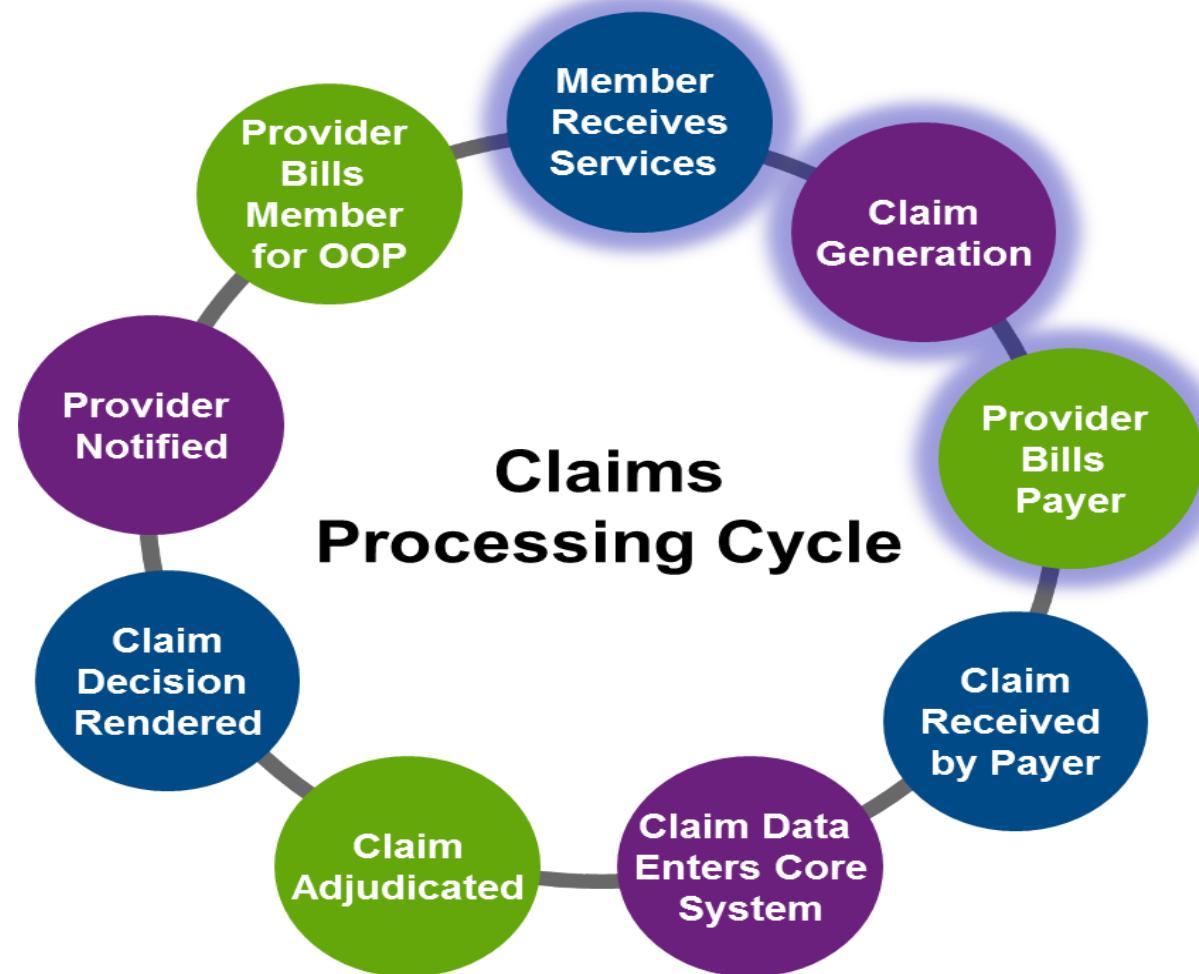
Claims Processing Cycle – Contd..



Claims Processing Cycle – Contd..

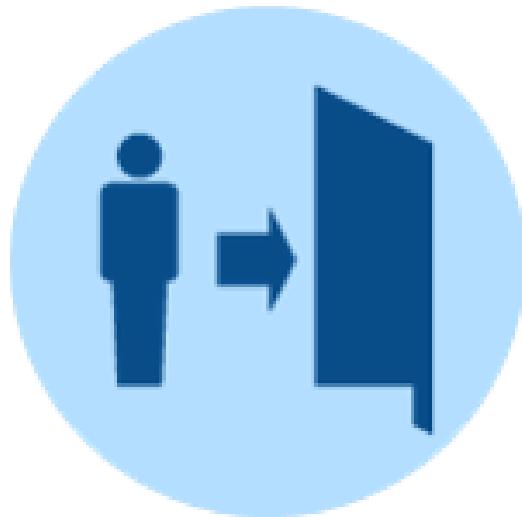


Claims Processing Cycle – Contd..

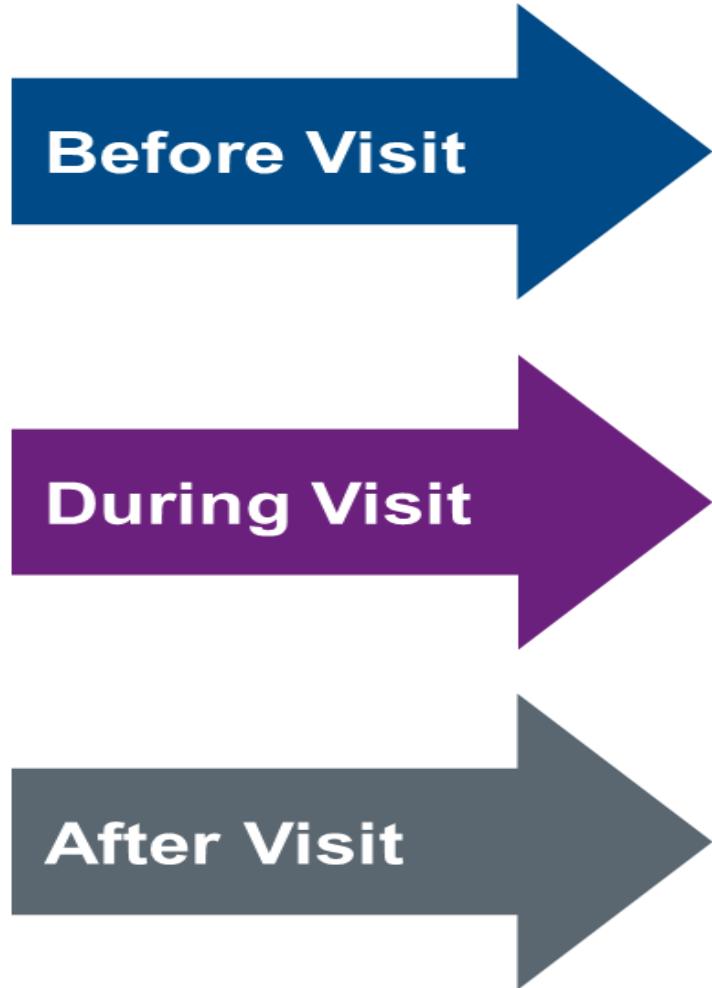


Member Visit Case Study

- Visit to PCP office for bronchitis symptoms
- Member has a PPO plan
- Deductible has not been met for the year
- Member's first visit in over 12 months to PCP

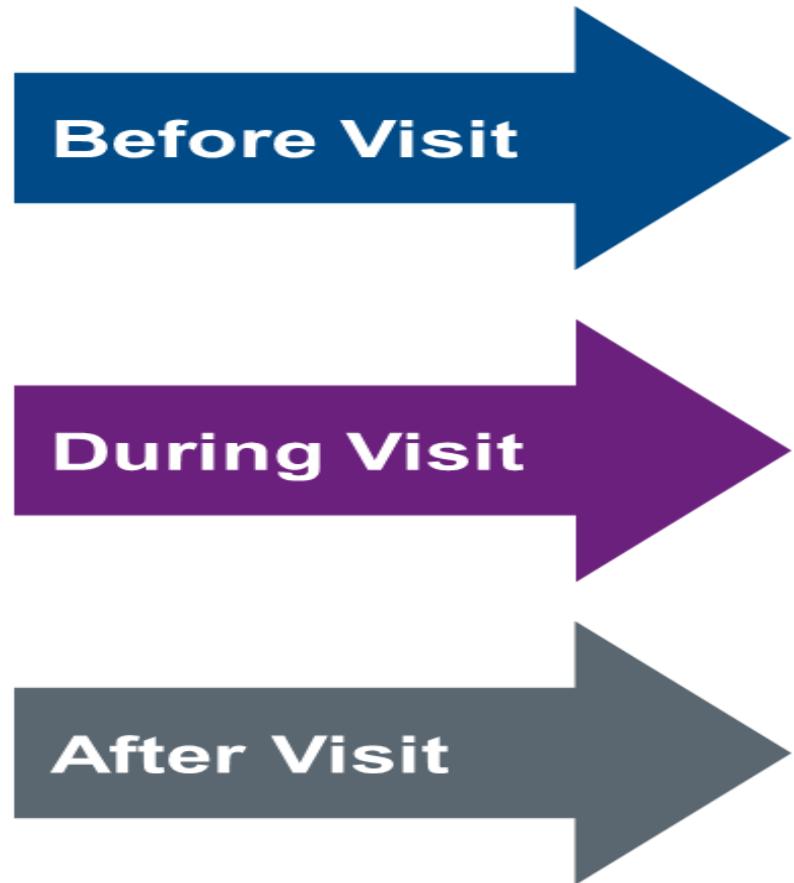


Claim Generation



- Eligibility Verification
- HIPAA Release

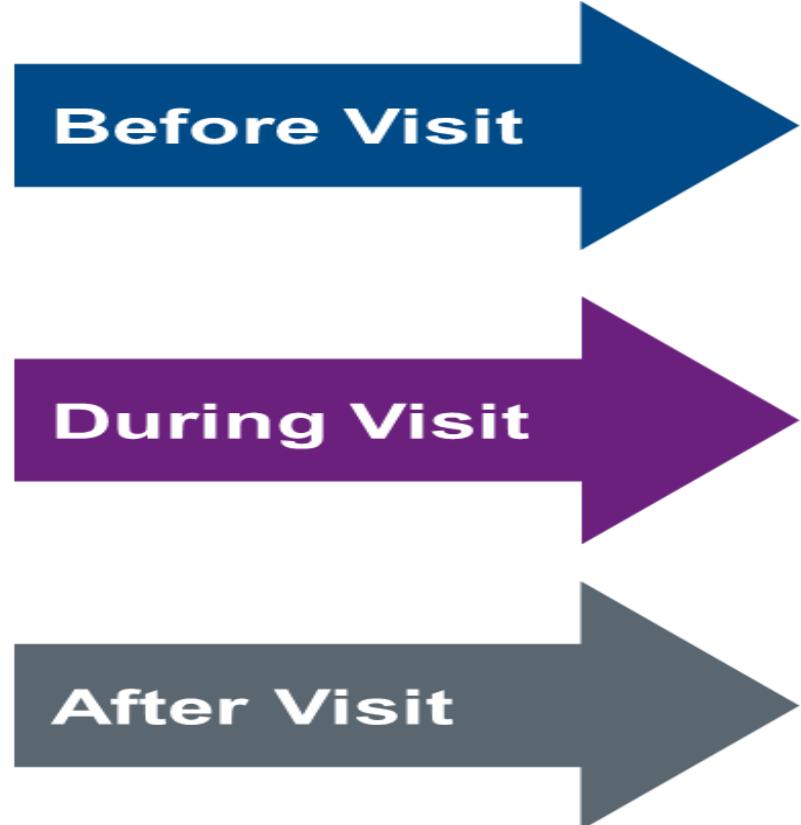
Claim Generation – Contd..



- Eligibility Verification
- HIPAA Release

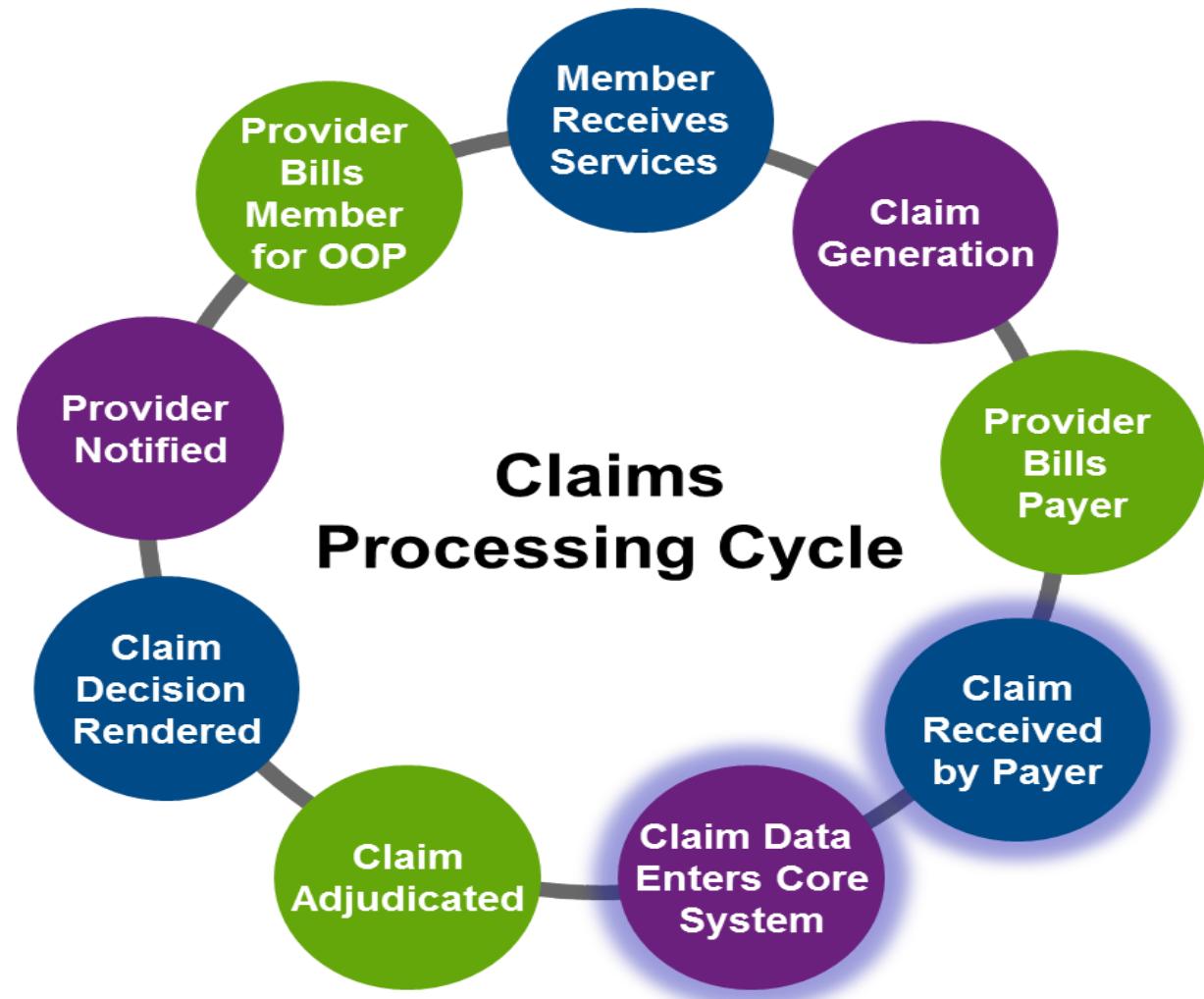
- Services Provided
- Documentation of Visit
- Medical Billing

Claim Generation – Contd..

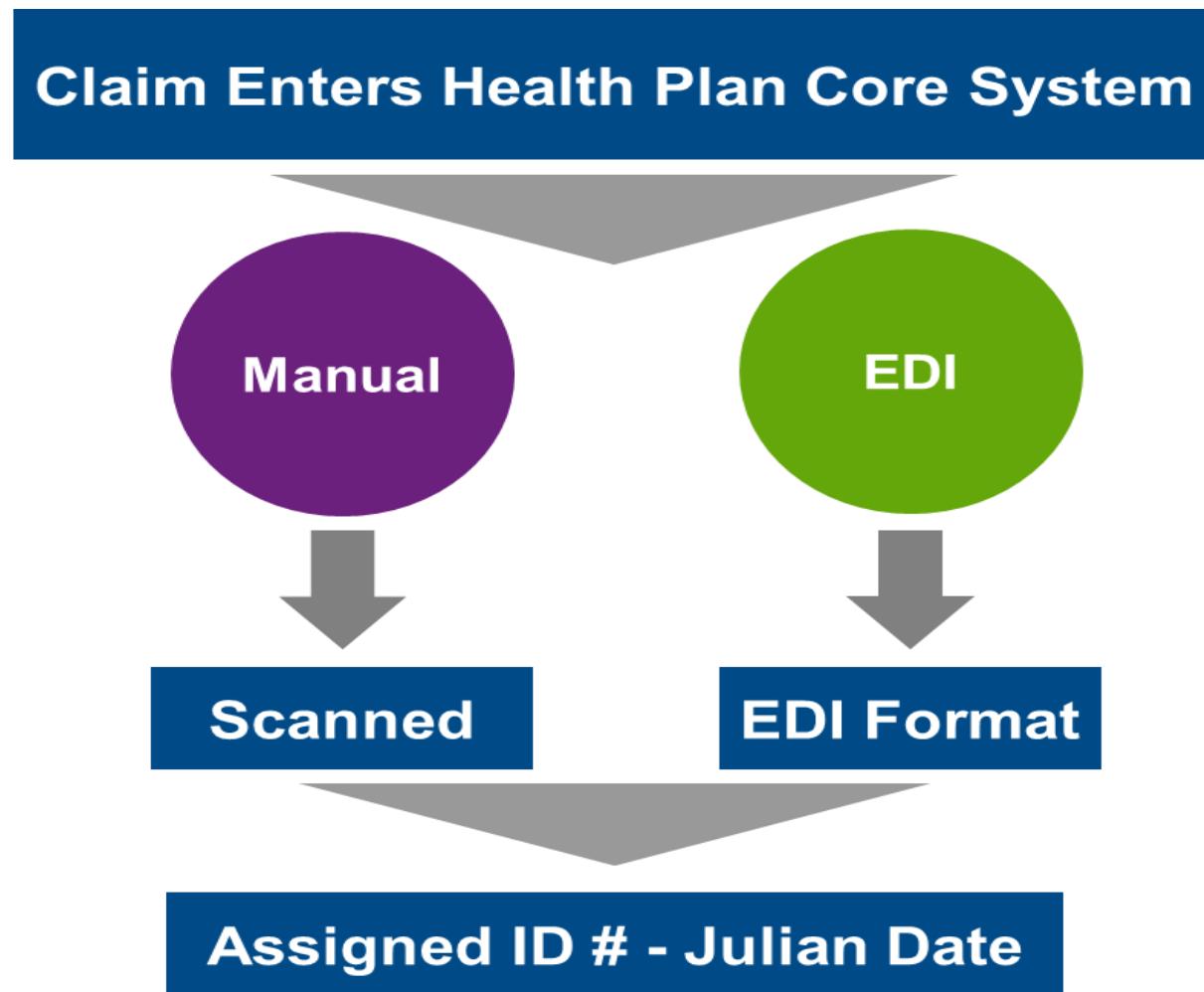


- Eligibility Verification
- HIPAA Release
- Services Provided
- Documentation of Visit
- Medical Billing
- Claim Created
- Claim Submission via EDI

Claims Processing Cycle – Contd..



Claims Processing Cycle – Contd..



Julian Date

What is a Julian Date?

- Method to represent the date in a 3-digit format
- Every day in the year is a sequential number

Examples:

- January 27 = 027
- March 5 = 064
- March 10 =

Julian Date – Contd..

What is a Julian Date?

- Method to represent the date in a 3-digit format
- Every day in the year is a sequential number

Examples:

- January 27 = 027
- March 5 = 064
- March 10 = 069

Payment Method

Payment Method	Provider is paid:
Lesser of	Contracted fee or the charge billed (the lesser of the two)

Payment Method – Contd..

Payment Method	Provider is paid:
Lesser of	Contracted fee or the charge billed (the lesser of the two)
Per Diem	A daily rate regardless of total charges incurred to provide services to the member

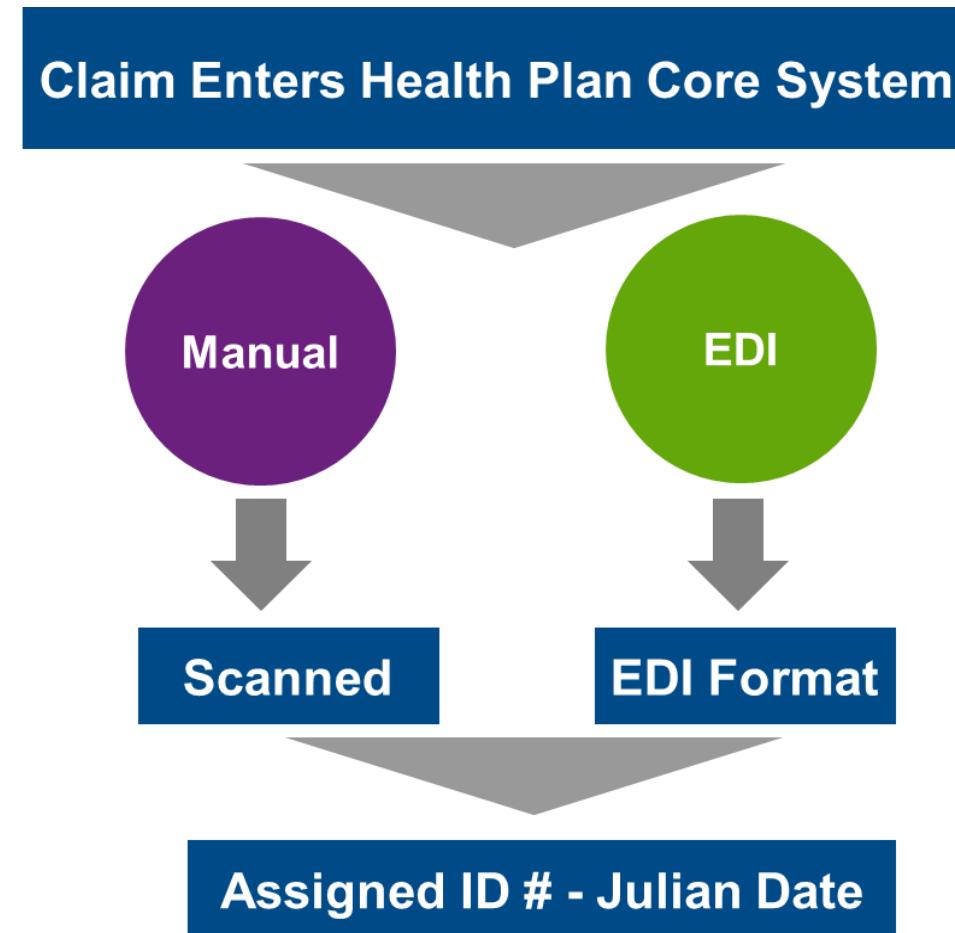
Payment Method – Contd..

Payment Method	Provider is paid:
Lesser of	Contracted fee or the charge billed (the lesser of the two)
Per Diem	A daily rate regardless of total charges incurred to provide services to the member
RBRVS	Resource-Based Relative Value Scale fees are paid based on amount of time and resources associated with services (RVU-Relative Value Unit)

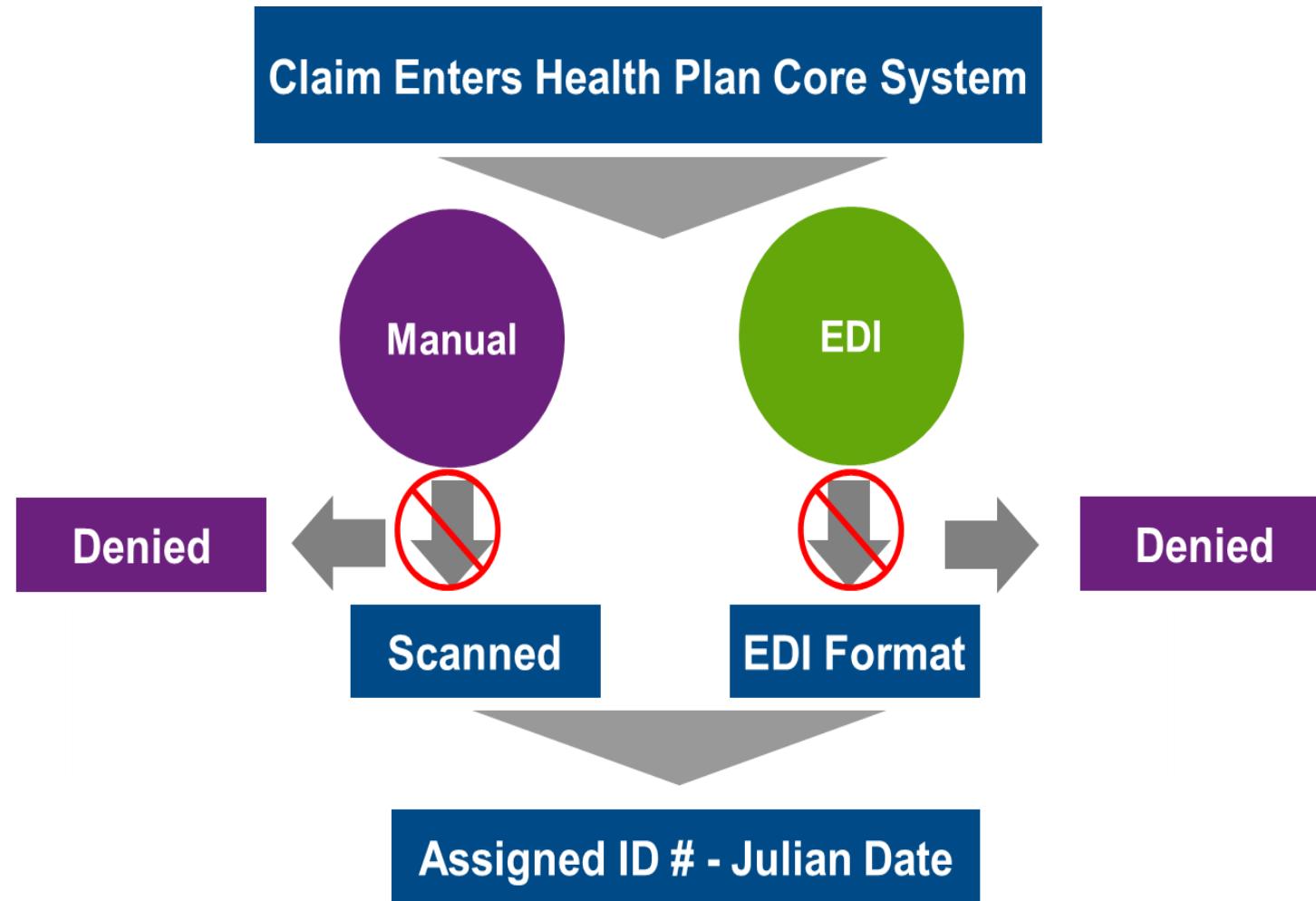
Payment Method – Contd..

Payment Method	Provider is paid:
Lesser of	Contracted fee or the charge billed (the lesser of the two).
Per Diem	A daily rate regardless of total charges incurred to provide services to the member.
RBRVS	Resource-Based Relative Value Scale fees are paid based on amount of time and resources associated with services (RVU-Relative Value Unit).
Global/Case Rate	A flat fee by bundling codes for payment for an episode for services for same diagnosis.

Claims Processing – Contd..

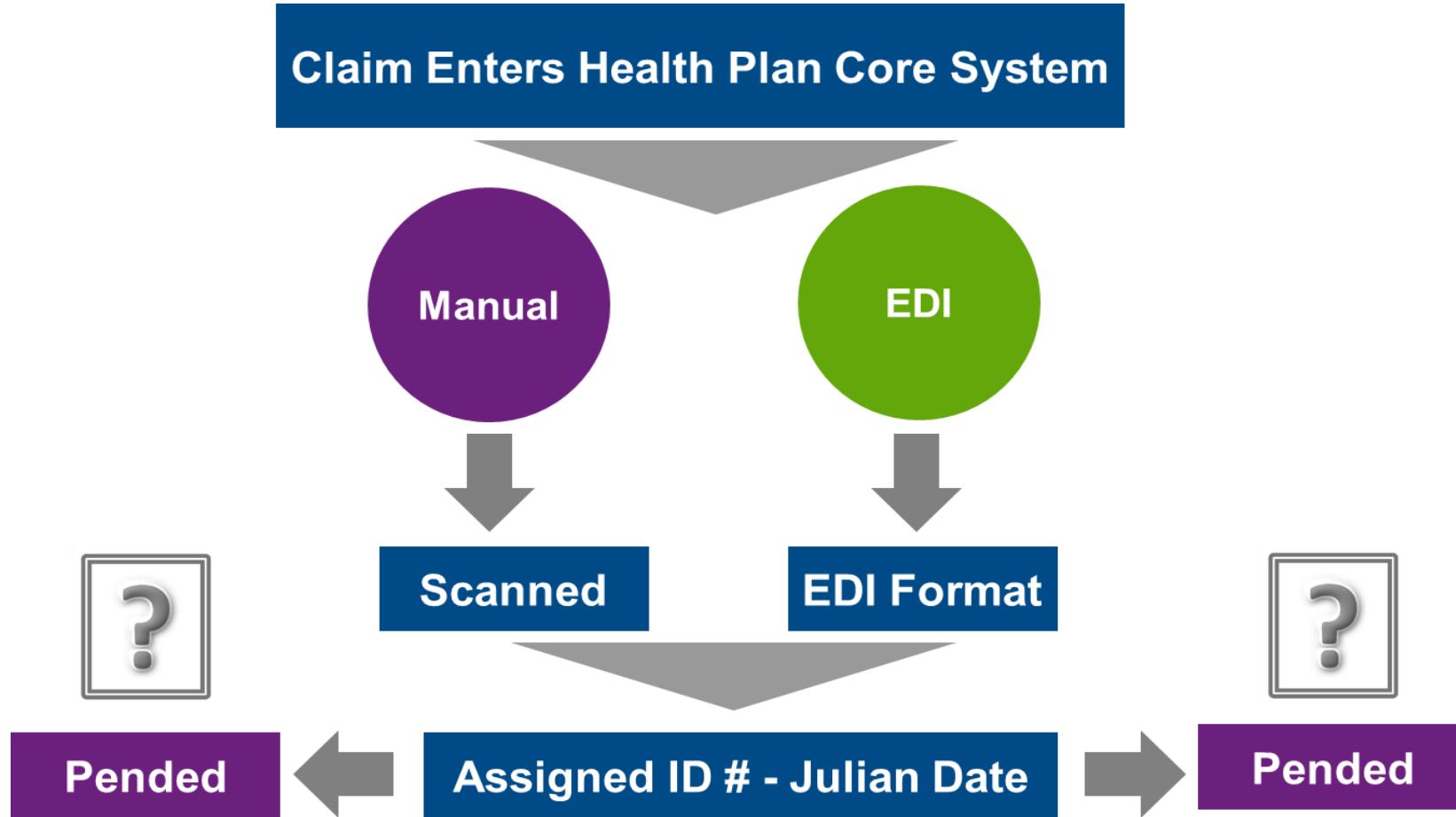


Claims Processing – Contd..

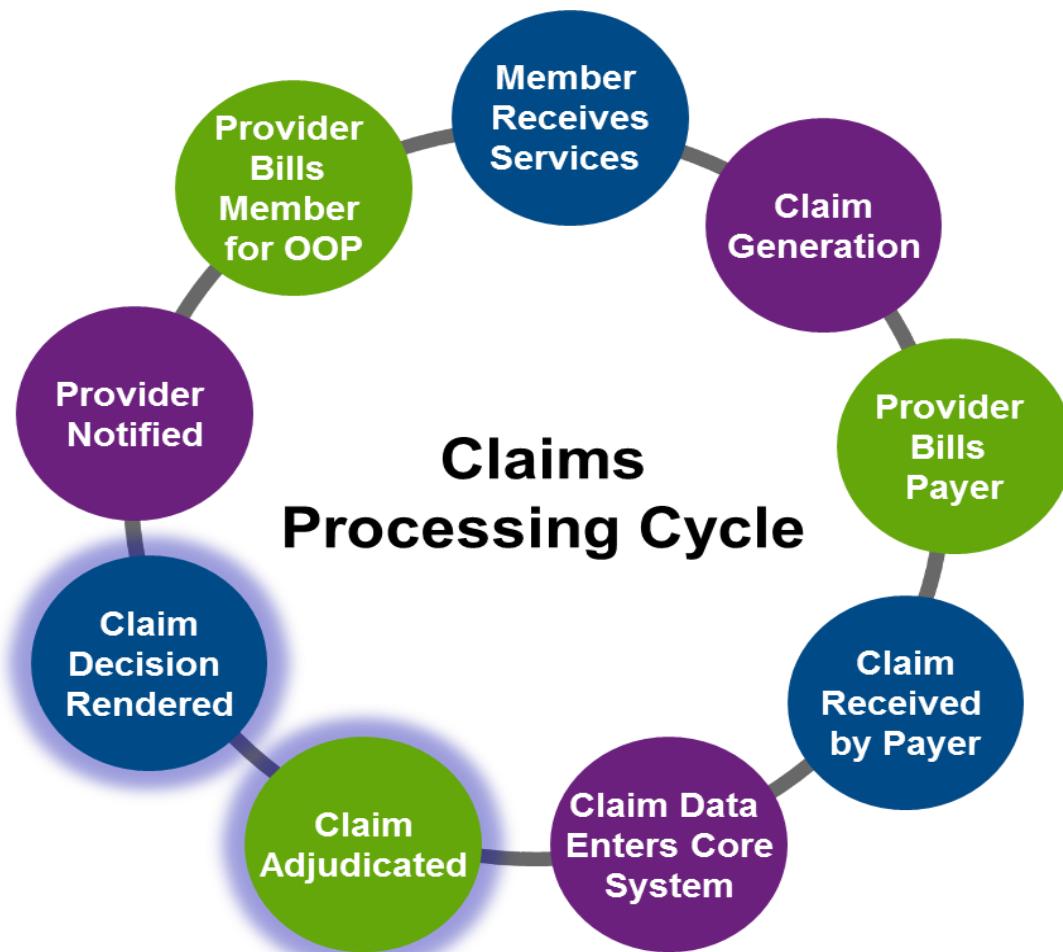


Claims Processing – Contd..

S



Claims Processing Cycle – Contd..



Claims Components

Key Claim Components

Member

Provider

Coding

Claims Components – Contd..

Key Claim Components

Member

Provider

Coding

Claim denies or rejects if key pieces are missing

Claims Components – Contd..

Key Claim Components



- Member Name
- Health Plan ID
- Date of Birth
- Gender
- Verification important
- Accuracy important

Claims Components – Contd..

Key Claim Components

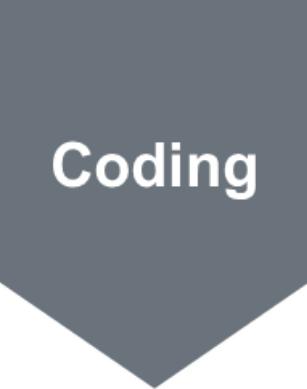
- Provider Name
- Tax ID Number
- National Provider Identifier (NPI)

A dark grey shield-shaped icon with the word "Provider" written in white capital letters in the center.

Provider

Claims Components – Contd..

Key Claim Components

A dark grey shield-shaped icon with the word "Coding" written in white.

Coding

Language of Healthcare:

- Represents Service Provided
- Reimbursement Code Based
- Benefits and Out of Pocket Costs

Language of Healthcare

CPT

Current Procedural Terminology : Professional Billing

- 99214 – Office visit
- 36415 – Venipuncture

ICD

International Statistical Classification of Disease and Related Health Problems : Professional and Facility Billing

- ICD-9: 250.00 – Diabetes
- ICD-10: E08.00 – Diabetes

Rev

Revenue Code: Facility Billing

- 0110 – Room & Board (Private)
- 0191 – Subacute Care – Level I

DRG

Diagnostic Related Groups: Facility Billing

- 292 – Heart Failure & Shock w/cc
- 089 – Concussion w/cc

POS

Place of Service : Professional and Facility Billing

- 11 – Office visit
- 21 – Inpatient Hospital

Required Claim Formats

- What are the two types of standard claim forms?



Required Claim Formats – Contd..

- What are the two types of standard claim forms?



CMS 1500



Required Claim Formats – Contd..

- What are the two types of standard claim forms?



CMS 1500



UB 04

Required Claim Formats – Contd..

- What are the two types of standard claim forms?



CMS 1500



UB 04

- What types of providers bill on the two forms?



Required Claim Formats – Contd..

- What are the two types of standard claim forms?



CMS 1500



UB 04

- What types of providers bill on the two forms?



Professional



Required Claim Formats – Contd..

- What are the two types of standard claim forms?



CMS 1500



UB 04



Professional



Facility

- What types of providers bill on the two forms?

CMS 1500 – Professional Claims

Standard claim form for non-institutional providers

Medicare requires EDI billing of the 1500

What are the three key claim components?



CMS 1500 – Professional Claims – Contd..

Provider Type	Service Example
Primary Care Physician	Hospital visit for a patient in the hospital
Specialty Care Physician	Surgery charges for knee replacement
Physician Assistant	Office visit for strep screening
DME Supplier	Charges for a wheelchair
Psychologist	Behavioral health consult



CMS 1500: Language of Healthcare

HCPCS

Health Care Common Procedure Coding System

- A0429 – Ambulance service, basic life support, ER transport
- L0120 – Cervical, flexible, non-adjustable foam collar

CPT

Current Procedural Terminology

- 99214 – Office visit
- 36415 – Venipuncture

ICD

International Statistical Classification of Disease and Related Health Problems

- ICD-9: 250.00 – Diabetes
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POS

Place of Service

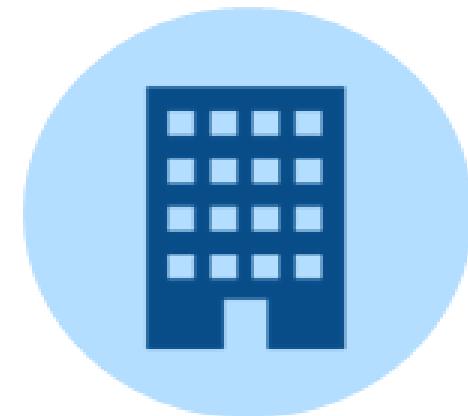
- 11 – Office visit
- 21 – Inpatient Hospital

UB 04 – Facility Claims

Standard claim form for institutional providers

Medicare requires EDI billing of the UB 04

What are the three key claim components?



UB 04 – Facility Claims – Contd..

Provider Type	Service Example
Inpatient Procedures	Hospital stay including associated supplies
Surgical Procedures	Non-physician surgery charges
Outpatient Procedures	Non-inpatient services, e.g., same day surgery
Radiology Procedures	Services provided for MRI or an x-ray
Home Health Services	Services provided in a patient's home



UB 04: Language of Healthcare

Rev

Revenue Code

- 0110 – Room & Board (Private)
- 0191 – Subacute Care – Level I

HCPCS

Health Care Common Procedure Coding System

- A0429 – Ambulance service, basic life support, ER transport
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ICD

International Statistical Classification of Disease and Related Health Problems

- ICD-9: 250.00 – Diabetes

DRG

Diagnostic Related Groups

- 292 – Heart Failure & Shock w/cc
- 089 – Concussion w/cc

POS

Place of Service

- 11 – Office visit
- 21 – Inpatient Hospital

CMS 1500 or UB 04?

- Patient Story: Injured Runner



CMS 1500 or UB 04? – Contd..

Provider	Services	Claim Form
Marathon City Hospital ER	ER, X-Ray, Casting Supplies	



CMS 1500 or UB 04? – Contd..

Provider	Services	Claim Form
Marathon City Hospital ER	ER, X-Ray, Casting Supplies	UB04



CMS 1500 or UB 04? – Contd..

Provider	Services	Claim Form
Marathon City Hospital ER	ER, X-Ray, Casting Supplies	UB04
Marathon City ER Physicians	ER Physician Consult	



CMS 1500 or UB 04? – Contd..

Provider	Services	Claim Form
Marathon City Hospital ER	ER, X-Ray, Casting Supplies	UB04
Marathon City ER Physicians	ER Physician Consult	CMS 1500



CMS 1500 or UB 04? – Contd..

Provider	Services	Claim Form
Marathon City Hospital ER	ER, X-Ray, Casting Supplies	UB 04
Marathon City ER Physicians	ER Physician Consult	CMS 1500
Ortho R Us Physicians	Orthopedic Physician Consult and Treatment in ER	



CMS 1500 or UB 04? – Contd..

Provider	Services	Claim Form
Marathon City Hospital ER	ER, X-Ray, Casting Supplies	UB 04
Marathon City ER Physicians	ER Physician Consult	CMS 1500
Ortho R Us Physicians	Orthopedic Physician Consult and Treatment in ER	CMS 1500



CMS 1500 or UB 04? – Contd..

Provider	Services	Claim Form
Marathon City Hospital ER	ER, X-Ray, Casting Supplies	UB 04
Marathon City ER Physicians	ER Physician Consult	CMS 1500
Ortho R Us Physicians	Orthopedic Physician Consult and Treatment in ER	CMS 1500
We See You Physicians	Radiologist Reading the X-ray	



CMS 1500 or UB 04? – Contd..

Provider	Services	Claim Form
Marathon City Hospital ER	ER, X-Ray, Casting Supplies	UB 04
Marathon City ER Physicians	ER Physician Consult	CMS 1500
Ortho R Us Physicians	Orthopedic Physician Consult and Treatment in ER	CMS 1500
We See You Physicians	Radiologist Reading the X-ray	CMS 1500



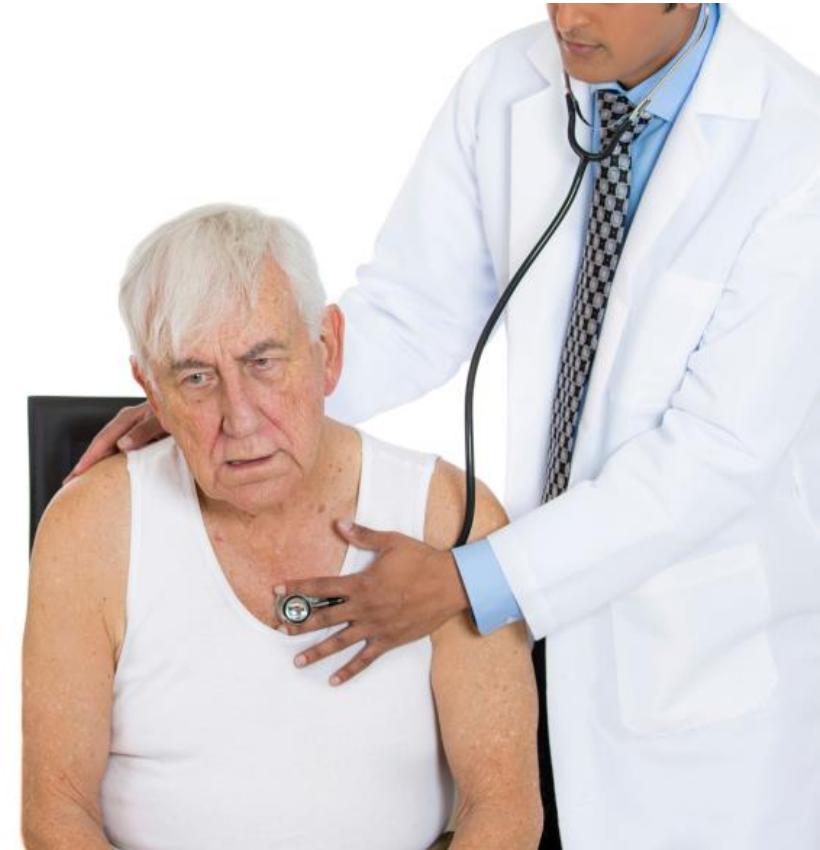
CMS 1500 or UB 04 ? – Contd..

- Patient Story: Motorcycle Accident

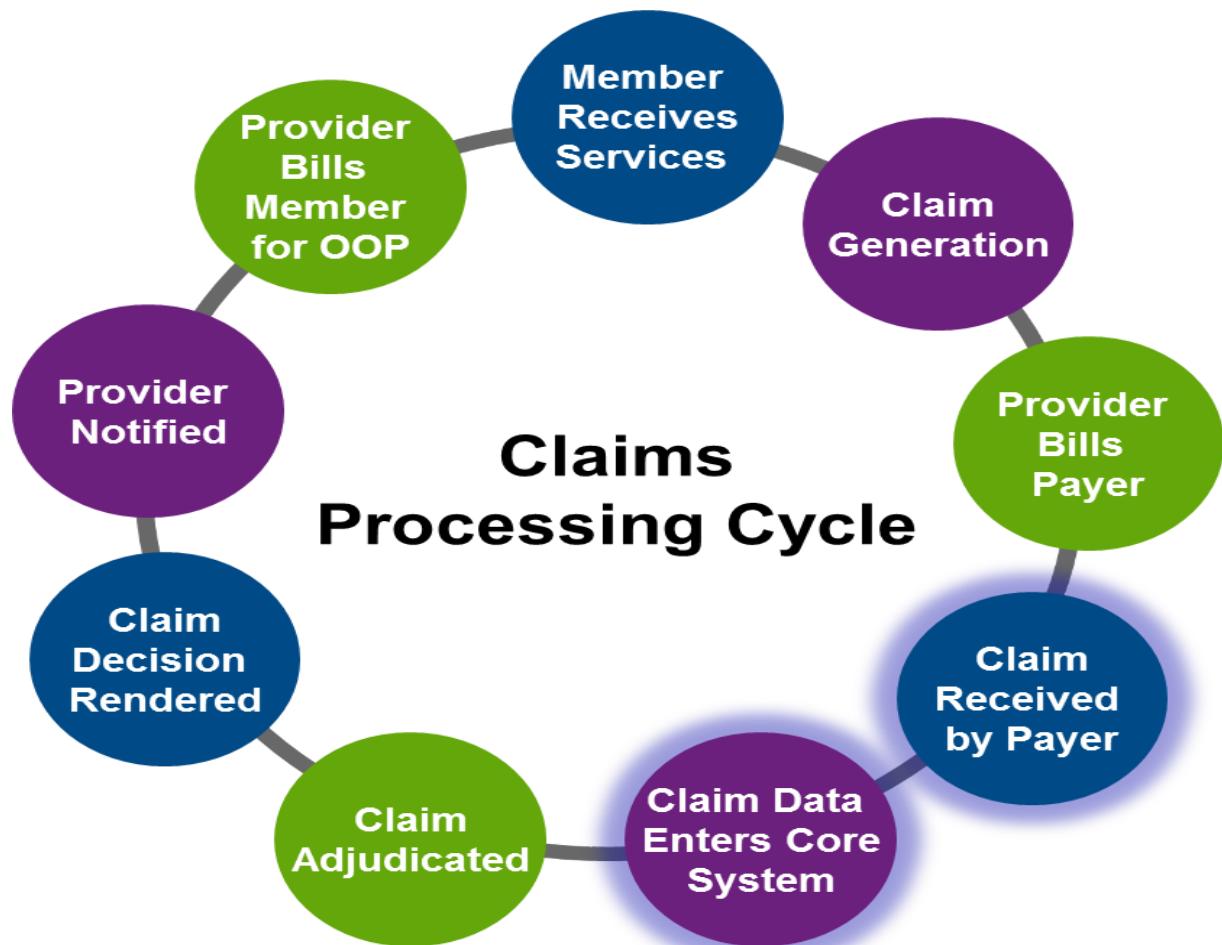


CMS 1500 or UB 04 ? – Contd..

- Patient Story: Cold and Cough Symptoms



Claims Processing Cycle – Contd..



Claims Administration

An **encounter** is a visit by a plan member to a provider of healthcare or related services.

An encounter report includes the services provided, the date of service, the diagnosis, and other information.

A health plan uses encounter reports to track utilization and provider practice patterns and as a basis for future capitation amounts.

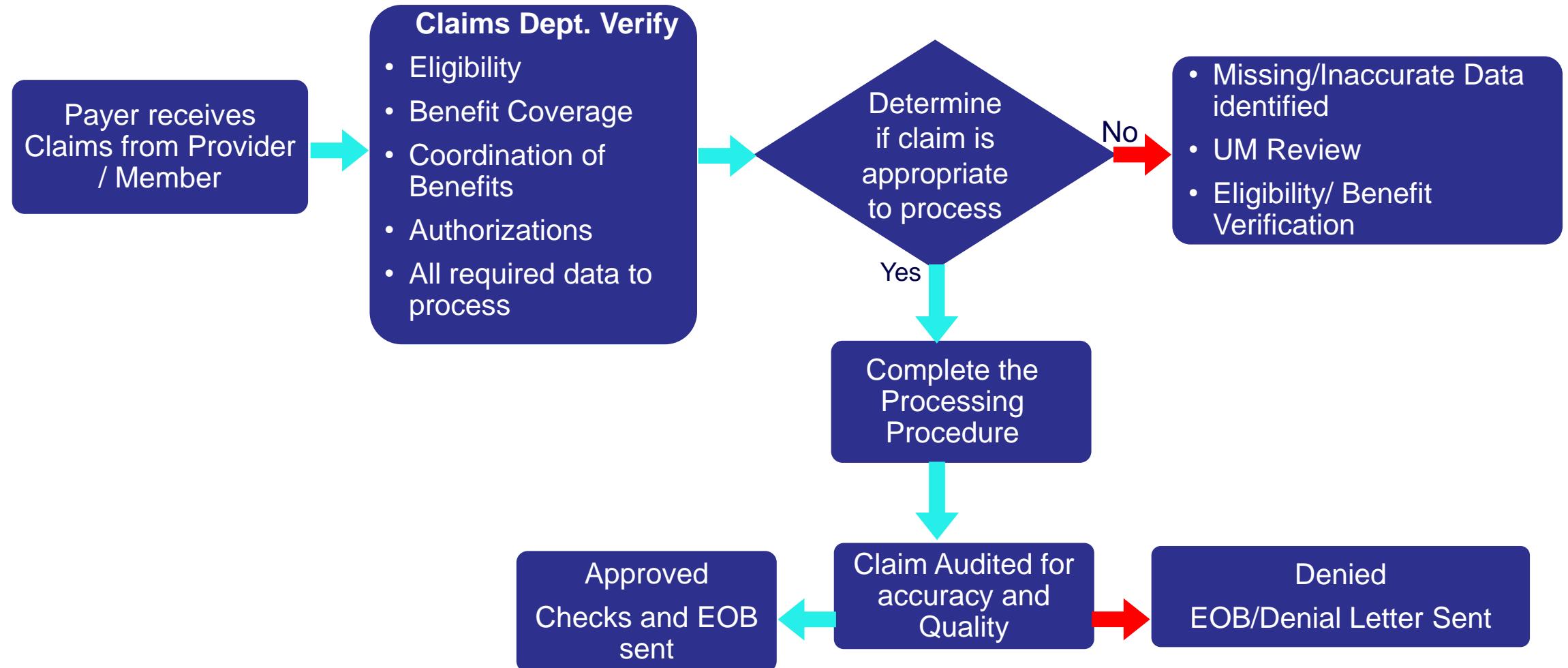
Claims administration department includes Data entry clerks, **claims examiners, processors, reviewers, analysts, or adjudicators**. Their exact duties may vary by title or plan, but essentially they review and adjudicate claims that are not electronically processed for some reason.

Claims adjustors deal with claims that have been paid incorrectly.

Claims Adjudication

- Adjudicating a claim (determining whether it should be paid and if so how much) can be thought of as satisfying a number of questions about the claim.
- Verifying Member Status - Was the member eligible to receive benefits under the plan at the time services were provided?
- Verifying Provider Status - Was the provider a participant in the plan's network?
- Determining Appropriateness of Treatment Provided - Was the treatment provided medically appropriate and/or medically necessary?
- Verifying Authorization –
 - Was a preauthorization or referral required for the service or treatment?
 - Was a preauthorization or referral given for the service or treatment?
- Verifying That the Service Is Covered by the Plan - Is the service covered under the plan?
- Verifying That the Service Was Actually Provided - Determining the Amount of Benefits to Pay
- What benefits are payable? - Does the member have other health insurance coverage?
- Claims Forms - UB-04(Institutional) and CMS-1500 (Professional)
- Edits- criteria that, if unmet, will prompt further investigation of a claim
- Claim investigation

Claims Adjudication – Contd..



Payment and Denial Explanations

Evidence of payment or denial

Provided to member, payer, or provider

Members receive an Explanation of Benefits

Providers receive a Remittance Advice

Medicare and most payers provide data through EDI

Explanation used to reconcile payment or denial

Explanation Of Benefit (EOB) - Sample

Medicare EOB Summary Info															
Claim Info - E14019000100				Primary Payer Info											
Submitter Name [REDACTED] PHYSICIANS SERVICE				ICN Number 00501140170504											
Address 1 Address 2 Medicare Paid Date 01/17/2014				Other Carrier Subs. Name Patient Name OC Subscriber ID Medicare Assignment A											
BillingProviderName Billing Provider NPI Billing Provider TIN [REDACTED]															
Submitted Charges \$744.02 Total Medicare Paid Amount \$48.15															
Claim Level Adjustment Info															
Paid Date	DOS	Medicare Allowed	Total Charges	Medicare Paid	Medicare Ded	Medicare Coins	Medicare Copay	Medicare Non-Covered	Medicare WO/DC						
01/17/2014	08/30/2013 - 08/30/2013	\$80.50	\$744.02	\$48.15	\$0.00	\$32.35	\$0.00	\$0.00	\$467.50						
Line Level Adjustment Info															
Item#	Rev. Code	Proc/ Mod	Paid Date	Medicare Allowed	Charge	Medicare Paid	Medicare Ded	Medicare Coins	Medicare CoPay	Medicare Non-Covered	Reason Code	Reason Amount	Medicare Write-off/ Discount	Reason Code	Reason Amount
1	0320	74230	01/17/2014	\$80.50	\$548.00	\$48.15	\$0.00	\$32.35	\$0.00	\$0.00			\$467.50	CO45	\$466.52
														CO253	\$0.98
2	0440	G8996GN	01/17/2014	\$0.00	\$0.01	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00			\$0.00		
3	0440	G8998GN	01/17/2014	\$0.00	\$0.01	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00			\$0.00		
4	0444	92611GN	01/17/2014	\$0.00	\$196.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00			\$0.00		
Total				\$80.50	\$744.02	\$48.15	\$0.00	\$32.35	\$0.00	\$0.00			\$467.50		

Explanation of Benefits – Contd..

- The EOB is sent by the Health Plan to covered individuals.
- EOBs explain what medical treatments and/or services have been paid or denied.
- Similar information to a remittance advice.
- Typically a simple version of remittance advice.



Thank you



Healthcare Foundations

Government Programs and Enrollment

Learning Services

Agenda

- Medicare
- Medicaid
- Regulatory Bodies
- Enrollment

Healthcare coverage for the aging and disabled populations

BENEFITS RELATED TO

Medicare – Contd..

Healthcare coverage for the aging and disabled populations

BENEFITS RELATED TO



Non-Hospital Services

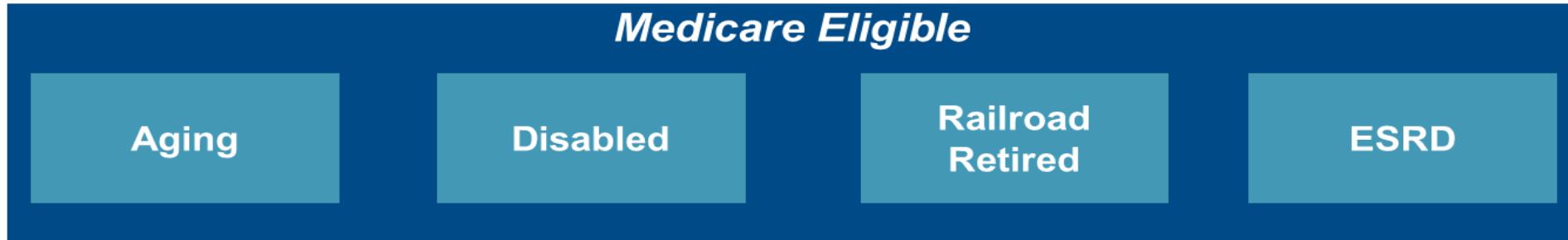


Hospital Services



Pharmacy Services

Medicare – Contd..



Facts:

- Must be 65 years of age or older
- May qualify even if still working

Medicare – Contd..

<i>Medicare Eligible</i>			
Aging	Disabled	Railroad Retired	ESRD
Facts: <ul style="list-style-type: none">• Must be 65 years of age or older• May qualify even if still working	Facts: <ul style="list-style-type: none">• Medical condition must last at least 12 months• Unable to work due to the disability		

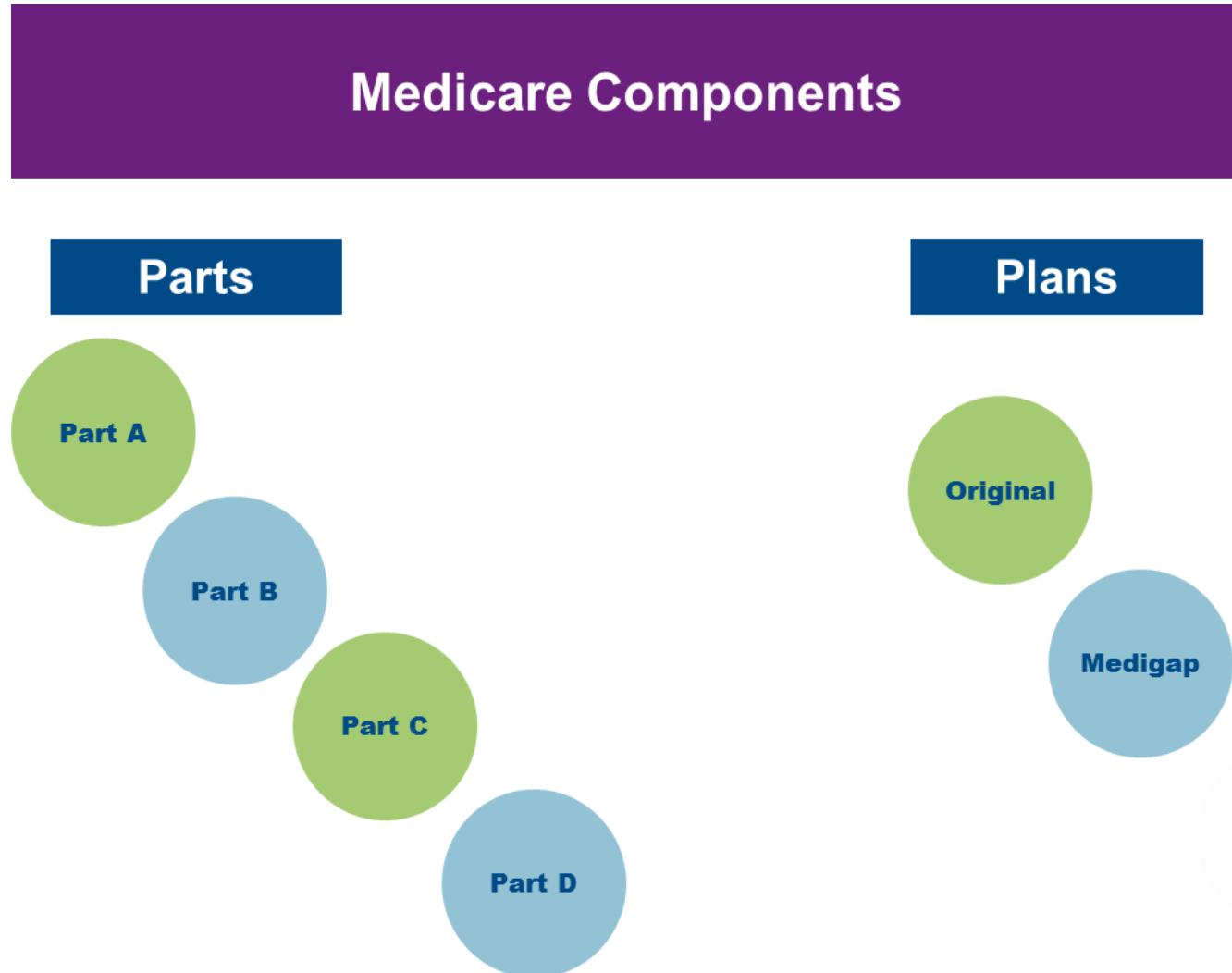
Medicare – Contd..

<i>Medicare Eligible</i>			
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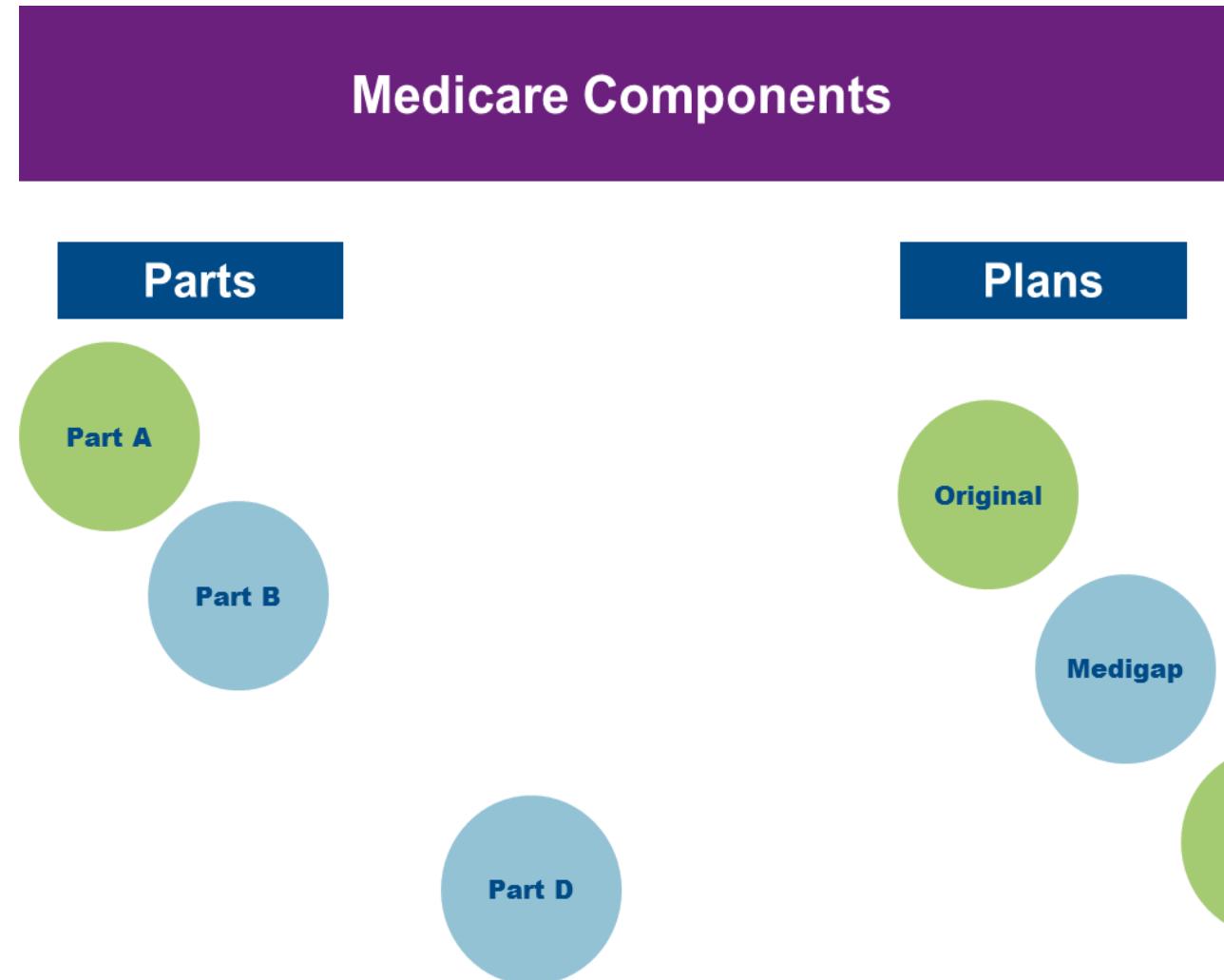
Medicare – Contd..

<i>Medicare Eligible</i>			
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Facts: <ul style="list-style-type: none">• Must be 65 years of age or older• May qualify even if still working	Facts: <ul style="list-style-type: none">• Medical condition must last at least 12 months• Unable to work due to the disability	Facts: <ul style="list-style-type: none">• Railroad Retirement Board benefit eligible	Facts: <ul style="list-style-type: none">• Individual is renal impaired• Need kidney transplant or regular dialysis to maintain normal function

Medicare – Contd..



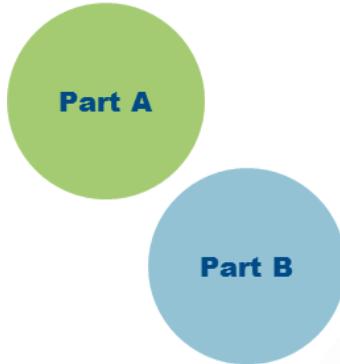
Medicare – Contd..



Medicare – Contd..

Medicare Components

Parts



Plans

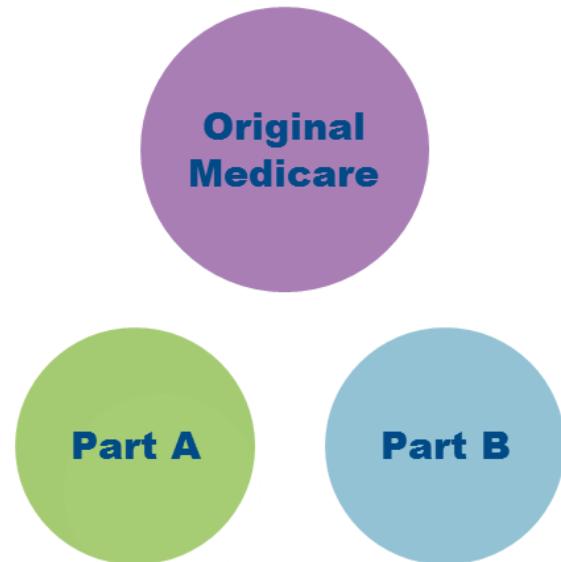


Medicare – Contd..

Medicare Components

Parts

Plans



Medicare – Part A

Hospital Benefits

Coinsurance

Indemnity Plan

Deductible

No Premium

Open Access

Medicare – Part B

Non-Hospital
Benefits

Indemnity Plan

Deductible

Open Access

Coinurance

Premium Cost

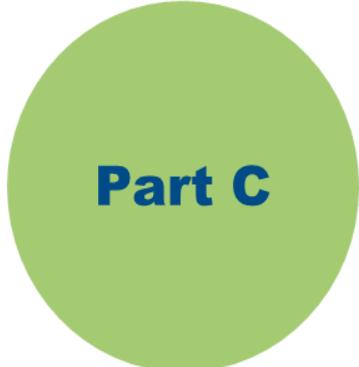


Medicare – Contd..

Medicare Components

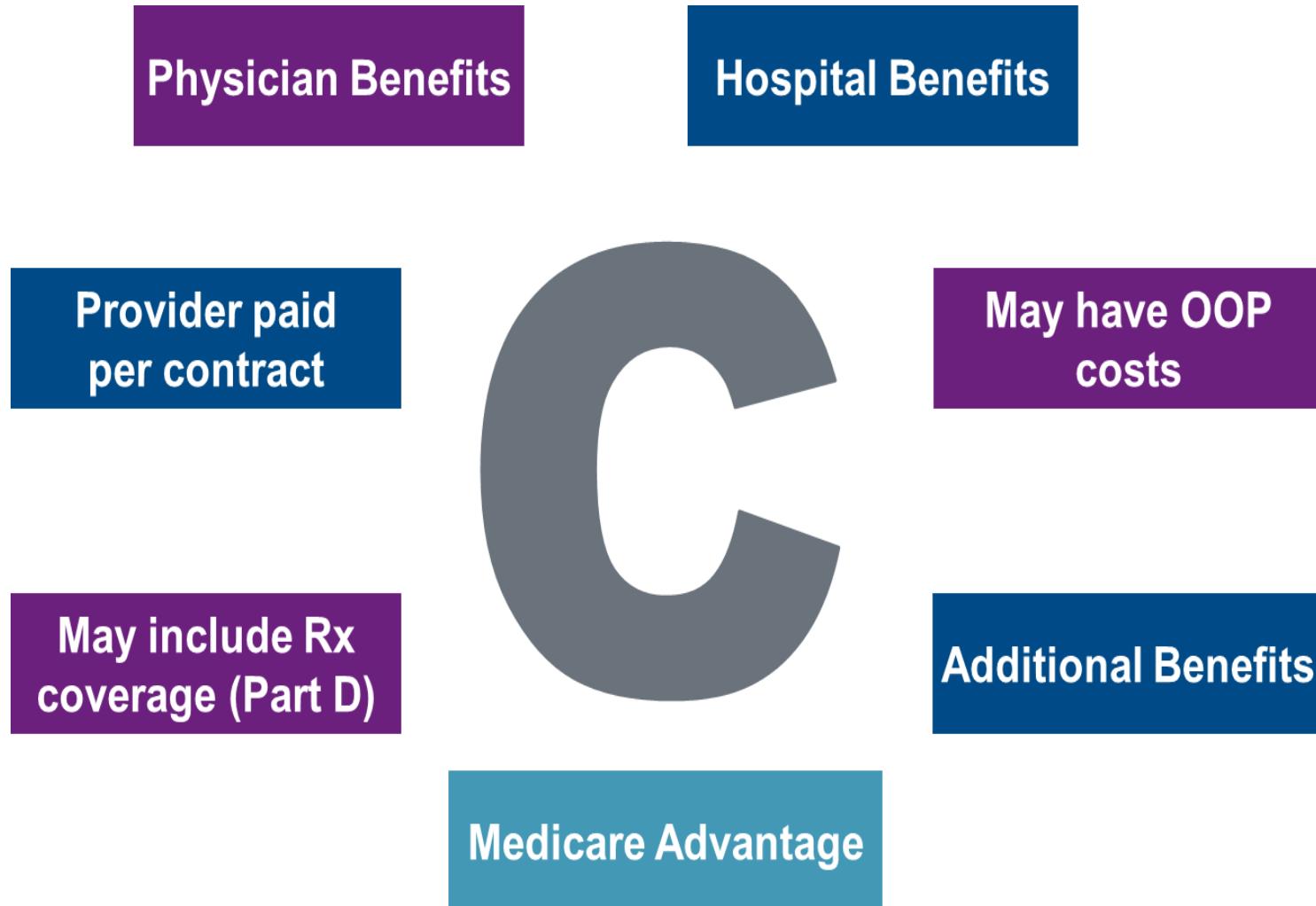
Parts

Plans

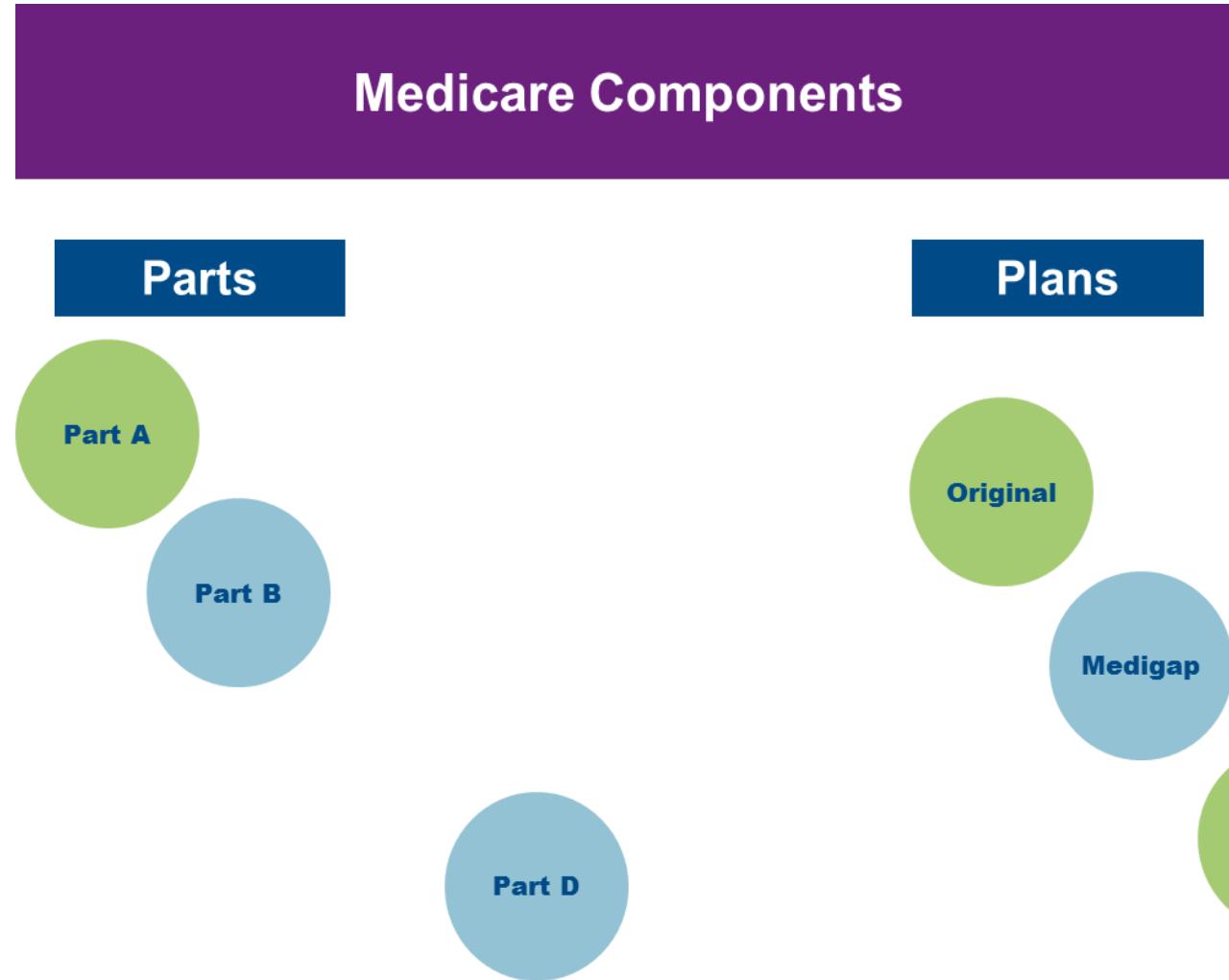


Part C

Medicare – Part C



Medicare – Contd..

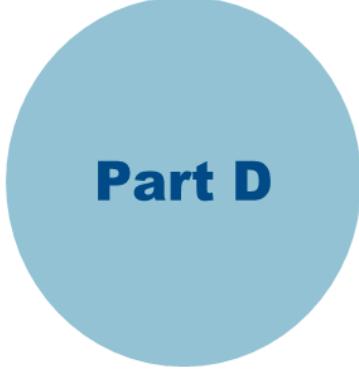


Medicare – Contd..

Medicare Components

Parts

Plans



Part D

Medicare – Part D

Pharmacy Benefits

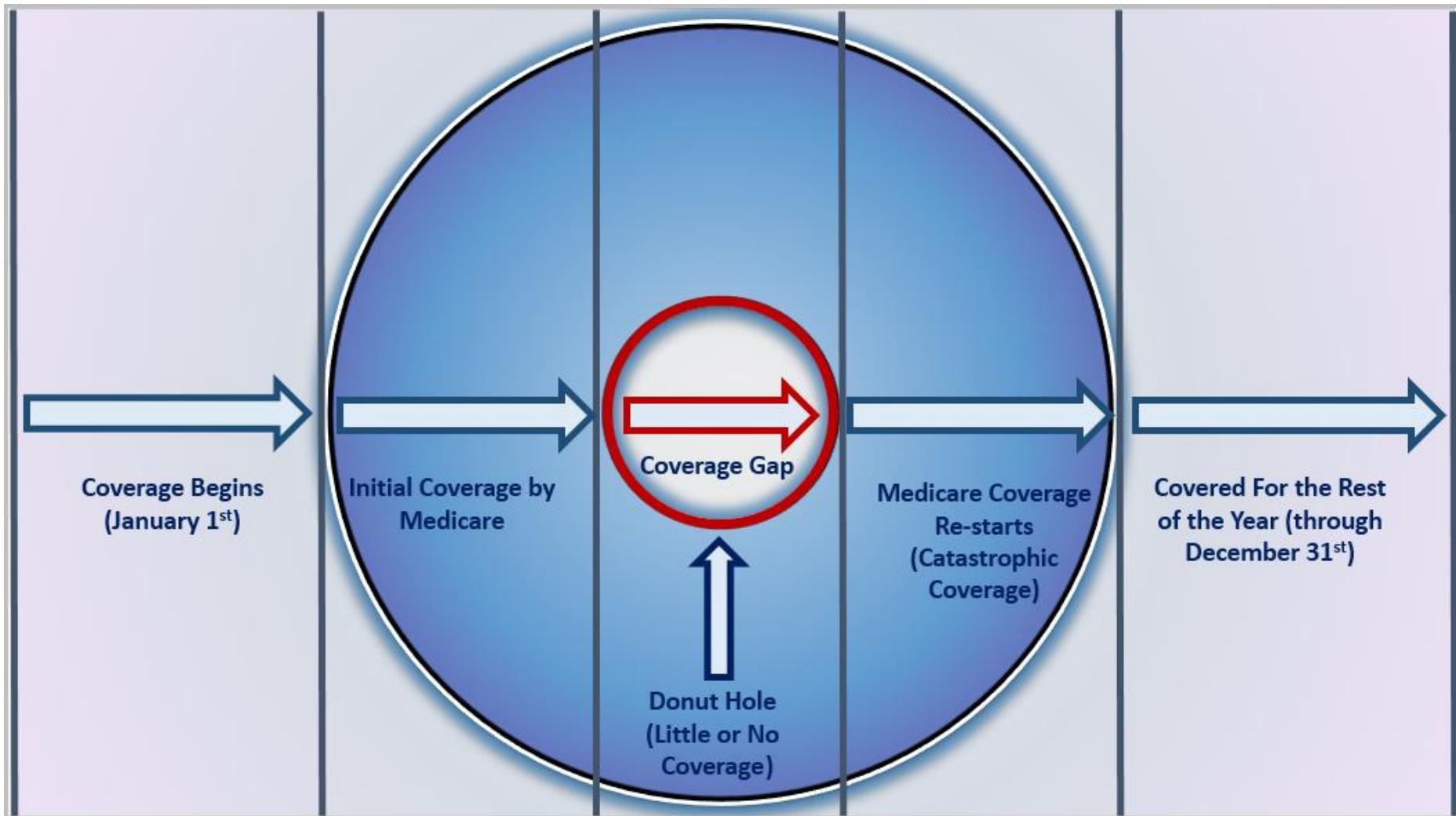
Coverage Gap

TrOOP

Late Enrollment
Penalty

Prescription Drug Plan

Part D – Coverage Gap



Medicare – Contd..

Medicare Components

Parts

Plans



Medigap

Medigap

Medicare Supplemental Insurance

Covers Out-of-Pocket costs

Federal and State Laws Regulate

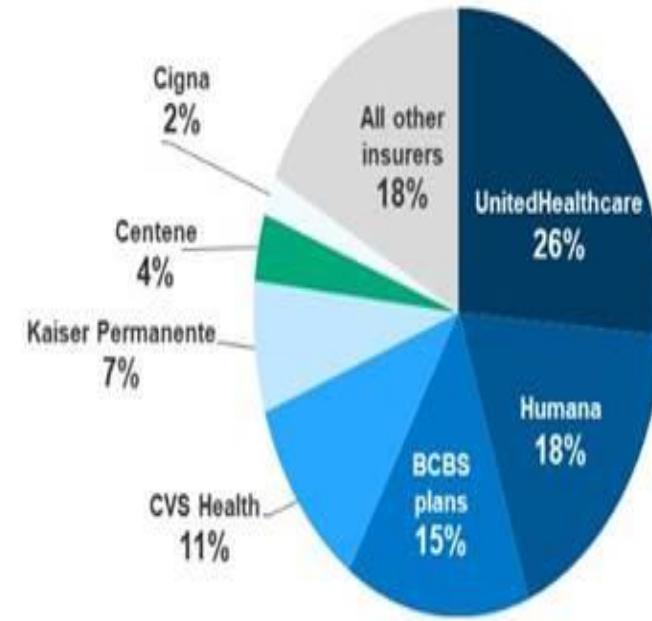
Individual Pay Premium

Benefits from Plan to Plan are Identical

Medicare Advantage

- In 2020, more than one-third (36%) of all Medicare beneficiaries – 24.1 million people out of 67.7 million Medicare beneficiaries overall – are enrolled in Medicare Advantage plans.
- Between 2019 and 2020, total Medicare Advantage enrollment grew by about 2.1 million beneficiaries, or 9 percent – nearly the same growth rate as the prior year.
- UnitedHealthcare and Humana together account for 44 percent of all Medicare Advantage enrollees nationwide, and the BCBS affiliates (including Anthem BCBS plans) account for another 15 percent of enrollment in 2020 .Four firms (CVS Health, Kaiser Permanente, Centene, and Cigna) account for another 23 percent of the Medicare Advantage enrollment in 2020 .
- For the fourth year in a row, enrollment in UnitedHealthcare's plans grew more than any other firm, increasing by more than 500,000 beneficiaries between March 2019 and March 2020

Medicare Advantage Enrollment by Firm or Affiliate, 2020



Total Medicare Advantage Enrollment, 2020 = 24.1 Million

Medicaid

Healthcare coverage for low-income populations

Healthcare coverage for low-income populations

KEY FACTS



Mandatory Coverage Groups

Medicaid – Contd..

Healthcare coverage for low-income populations

KEY FACTS



Mandatory Coverage Groups



State Administered

Medicaid – Contd..

Healthcare coverage for low-income populations

KEY FACTS



Mandatory Coverage Groups



State Administered



Federally Funded

Medicaid – Contd..

Low-Income Eligible Populations

Children

Pregnant
Women

Adults and
Elderly

Disabled

Medicaid – Contd..



Facts:

- Most States expand benefits or coverage for children
- Initiatives to find and enroll children in most States

Medicaid – Contd..

<i>Low-Income Eligible Populations</i>			
Children	Pregnant Women	Adults and Elderly	Disabled
Facts:		Facts:	
<ul style="list-style-type: none">• Most States expand benefits or coverage for children• Initiatives to find and enroll children in most States		<ul style="list-style-type: none">• Income threshold is extended to 185%• Medicaid funds 40% of all births in the U.S.	

Medicaid – Contd..

<i>Low-Income Eligible Populations</i>			
Children	Pregnant Women	Adults and Elderly	Disabled
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Medicaid – Contd..

<i>Low-Income Eligible Populations</i>			
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Medicaid/Medicare Comparison

	Medicare	Medicaid
Benefits	Similar	Similar
Funding		
Administered		
Eligible Groups		

Medicaid/Medicare Comparison – Contd..

	Medicare	Medicaid
Benefits	Similar	Similar
Funding	Federal	Federal
Administered		
Eligible Groups		

Medicaid/Medicare Comparison – Contd..

	Medicare	Medicaid
Benefits	Similar	Similar
Funding	Federal	Federal
Administered	Federal-Level	State-Level
Eligible Groups		

Medicaid/Medicare Comparison – Contd..

	Medicare	Medicaid
Benefits	Similar	Similar
Funding	Federal	Federal
Administered	Federal-Level	State-Level
Eligible Groups	Elderly/Aging Population	
	Disabled	
	ESRD	
	Railroad Retired	

Medicaid/Medicare Comparison – Contd..

	Medicare	Medicaid
Benefits	Similar	Similar
Funding	Federal	Federal
Administered	Federal-Level	State-Level
Eligible Groups	Elderly/Aging Population	Children
	Disabled	Disabled
	ESRD	Pregnant Women
	Railroad Retired	Non-disabled Adults/Elderly

Insurance Oversight and Administration

CMS provides oversight for:

- Medicare
- Medicaid
- HIPAA
- Other Key Programs

State Regulation:

- Department of Commerce and Insurance
- State Health Insurance Assistance Program (SHIP)

Governance Hierarchy

President and Congress

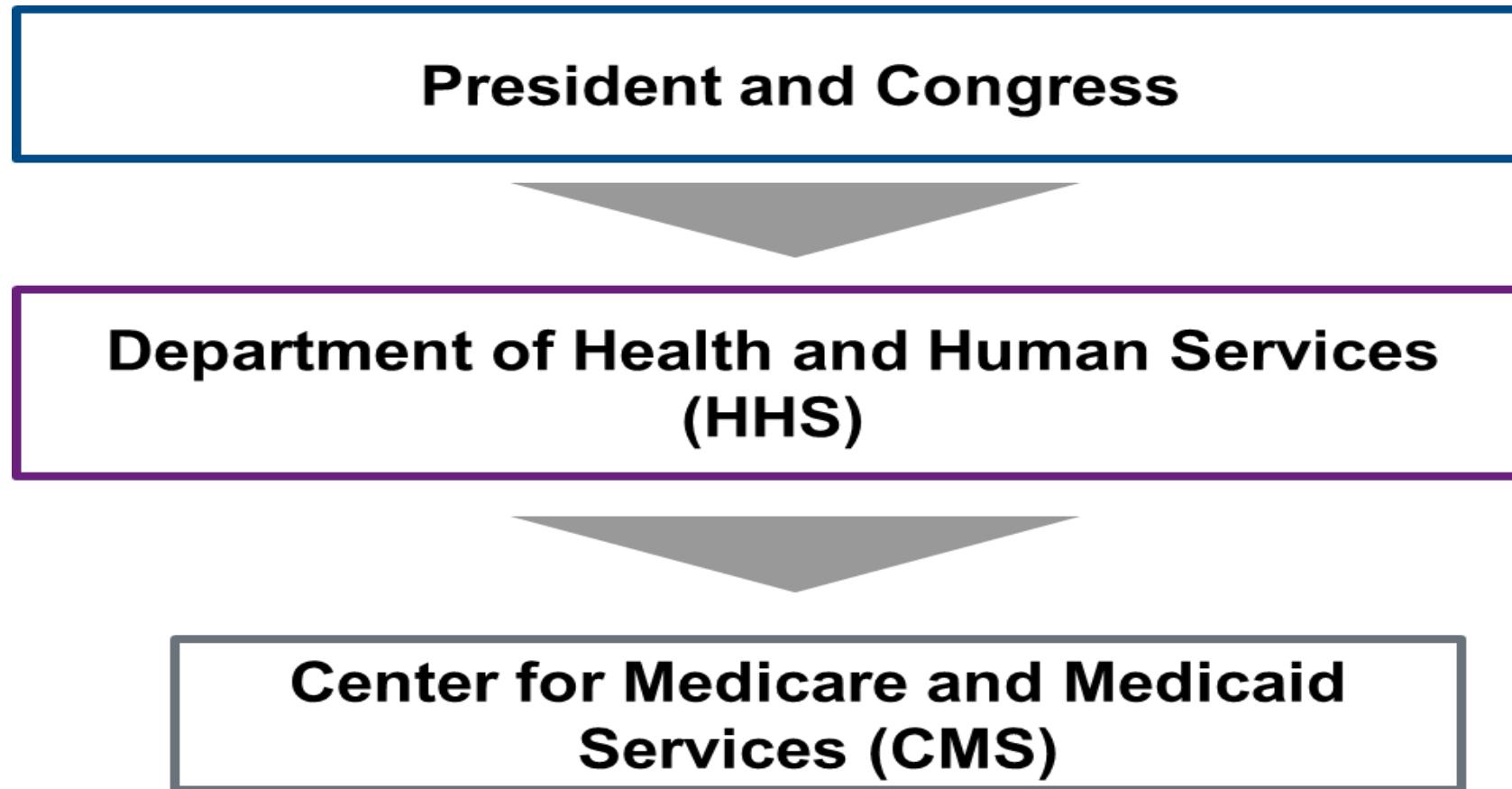


Governance Hierarchy – Contd..

President and Congress

**Department of Health and Human Services
(HHS)**

Governance Hierarchy – Contd..



Office of Inspector General (OIG)

Focus on Fraud and Abuse



Largest OIG
Assist Healthcare Industry
Focus on Oversight
Large Healthcare Budget
Create Public Awareness

National Committee for Quality Assurance (NCQA)

Stamp of Approval for Health Plans

NCQA Quality Seal – Reliable Payer Indicator

HEDIS® – Healthcare Effectiveness Data and Information Set

- Performance Measurement Tool
- Allows apples to apples comparisons

Medicare Stars Ratings – Quality Indicator



Joint Commission Accreditation (JCO)

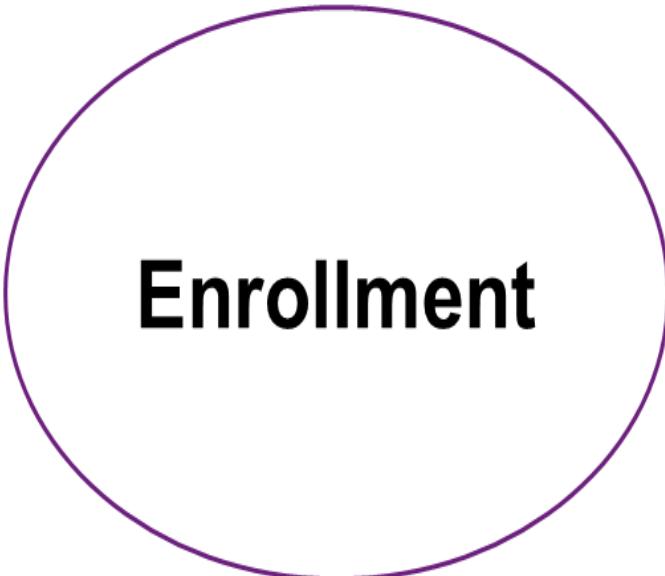
Joint Commission Accreditation for Healthcare Organizations

JCO Quality Seal – Reliable Provider Indicator

Several Categories of Accreditation

- Based on Provider Type, e.g. Hospital, Laboratory, etc.

Enrollment



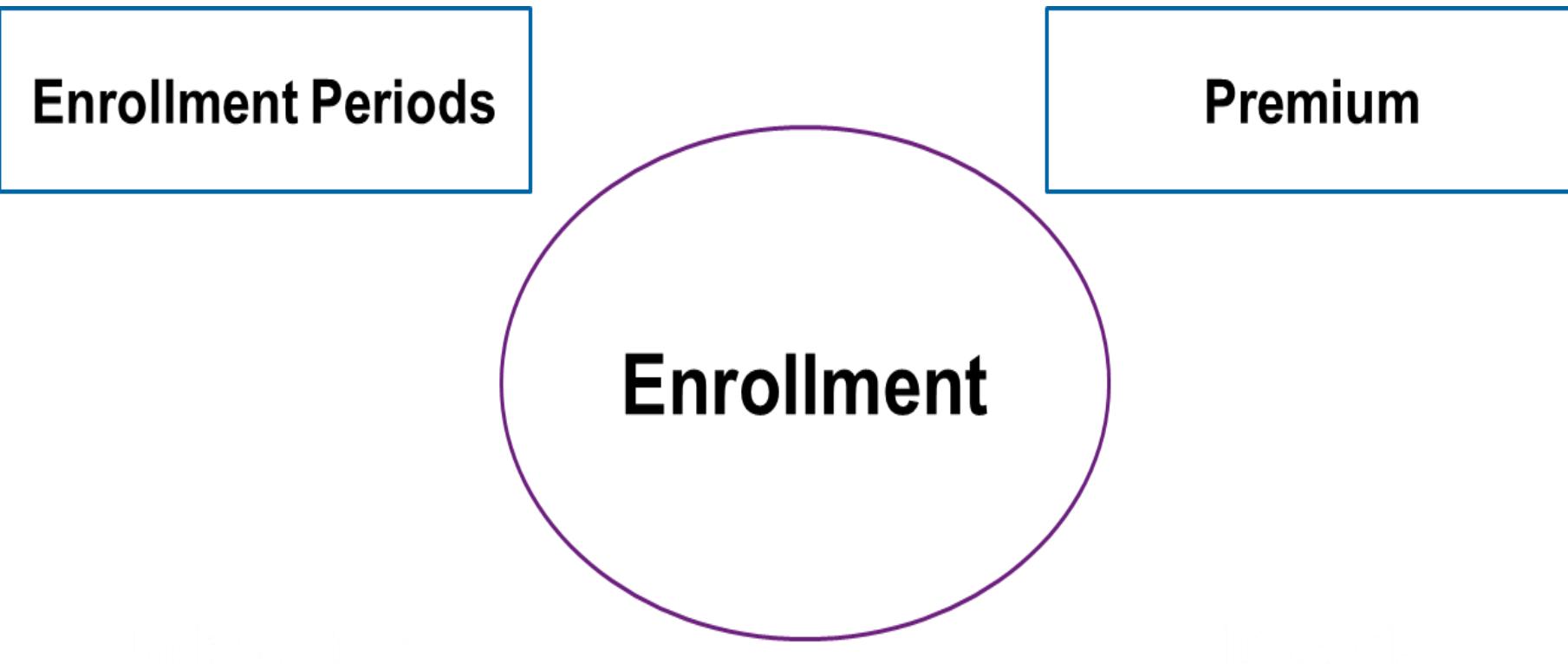
Enrollment

Enrollment – Contd..

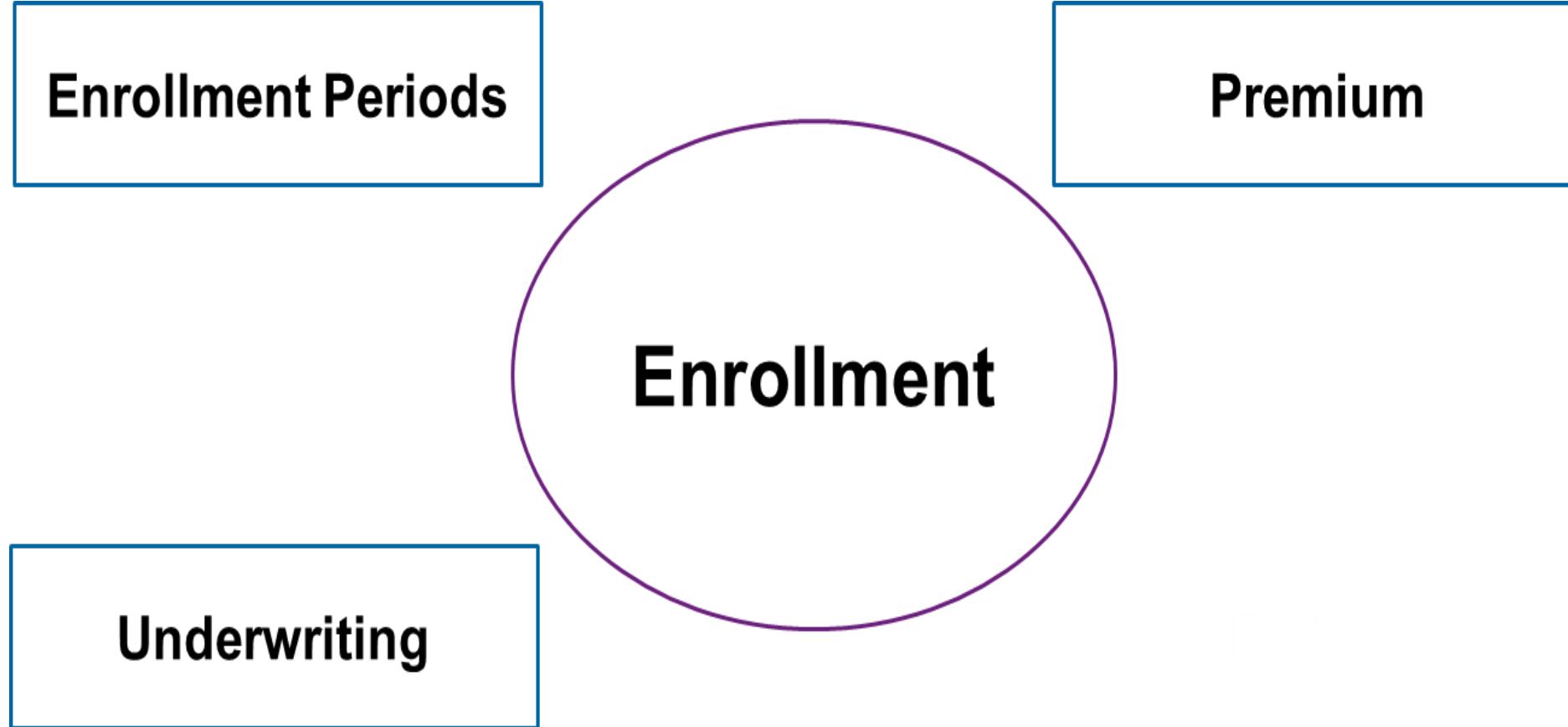
Enrollment Periods

Enrollment

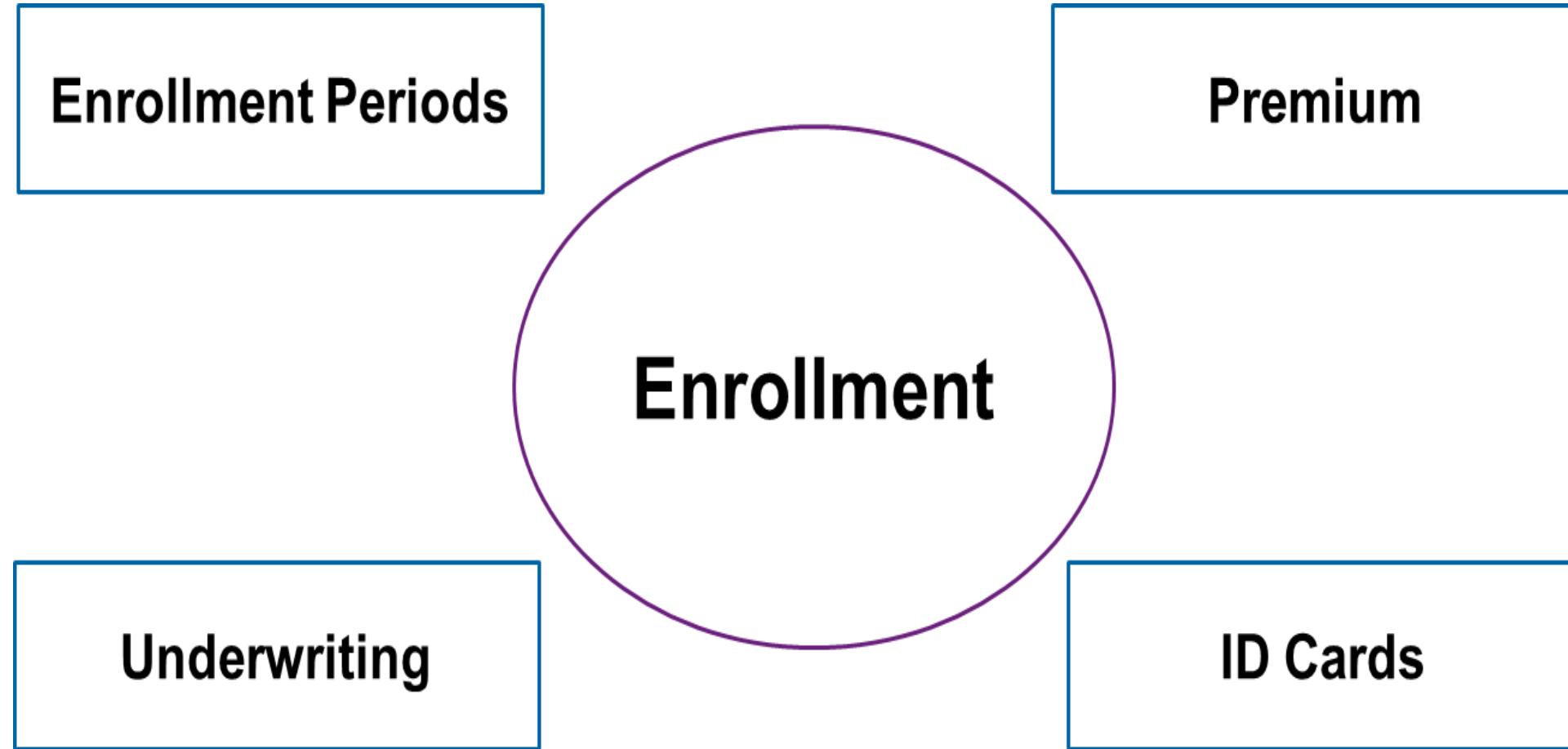
Enrollment – Contd..



Enrollment – Contd..



Enrollment – Contd..



Enrollment Periods

Enrollment Periods

- Life-qualifying event (birth of a baby)
- Newly eligible (new employee)

Typical Open Enrollment Period

- Fourth Quarter (October – December)

Medicare Initial Enrollment Period

Innitial Enrollment Period

The 7 Month Window to Enroll in Medicare



Medicare Initial Enrollment Period – Contd..

Part A and Part B:

- If enrolled up to 3 months prior then:
 - Effective date is 65th birthday
- If the 65th birthday is first day of the month:
 - Effective date begins in the prior month
- Enrollment during month of birthday and 3 months after:

If you enroll in this month of your initial enrollment period	Your coverage starts
The month you turn 65	1 month after enrollment
1 month after you turn 65	2 months after enrollment
2 months after you turn 65	3 months after enrollment
3 months after you turn 65	3 months after enrollment

Medicare General Enrollment Period

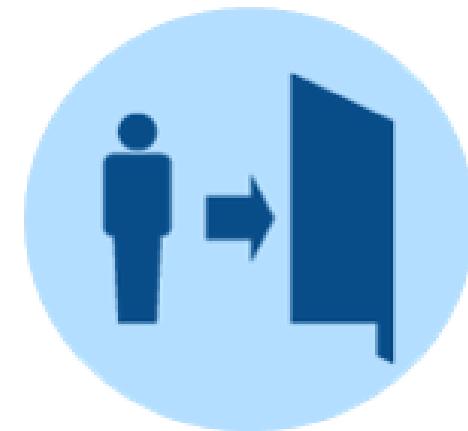
Allows late enrollment

Those who missed the seven month window

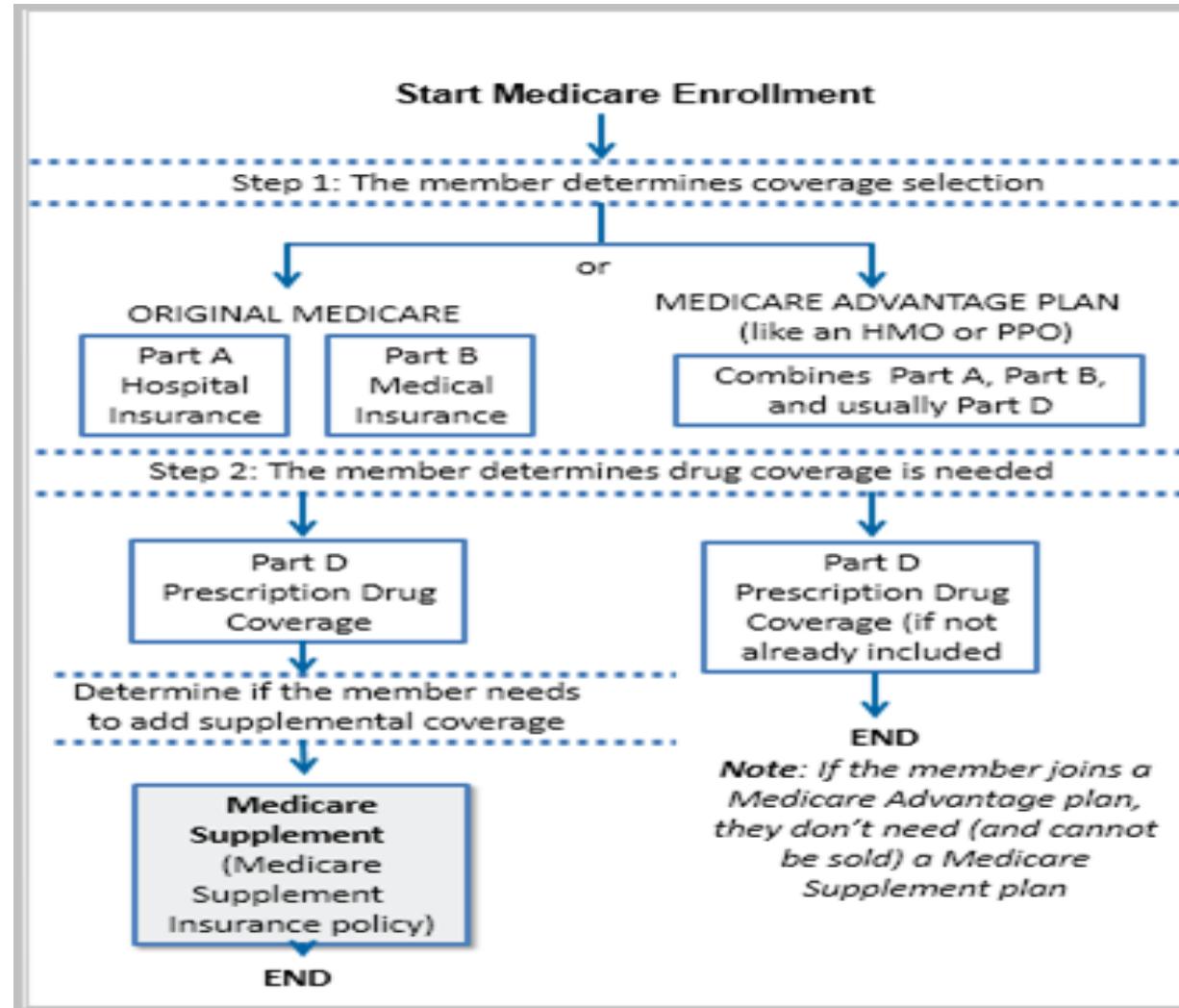
January 1 – March 31

Effective date – July 1

Higher Part B premium



Medicare Enrollment Overview



Underwriting

Assessing risk

Factors reviewed:

- Age
- Gender
- Geographic region
- Industry
- Past medical history/data

Performed by actuaries



Premium

The individual or group cost to receive healthcare coverage.

Paid monthly in exchange for guarantee of services/benefits.



Premium Determination

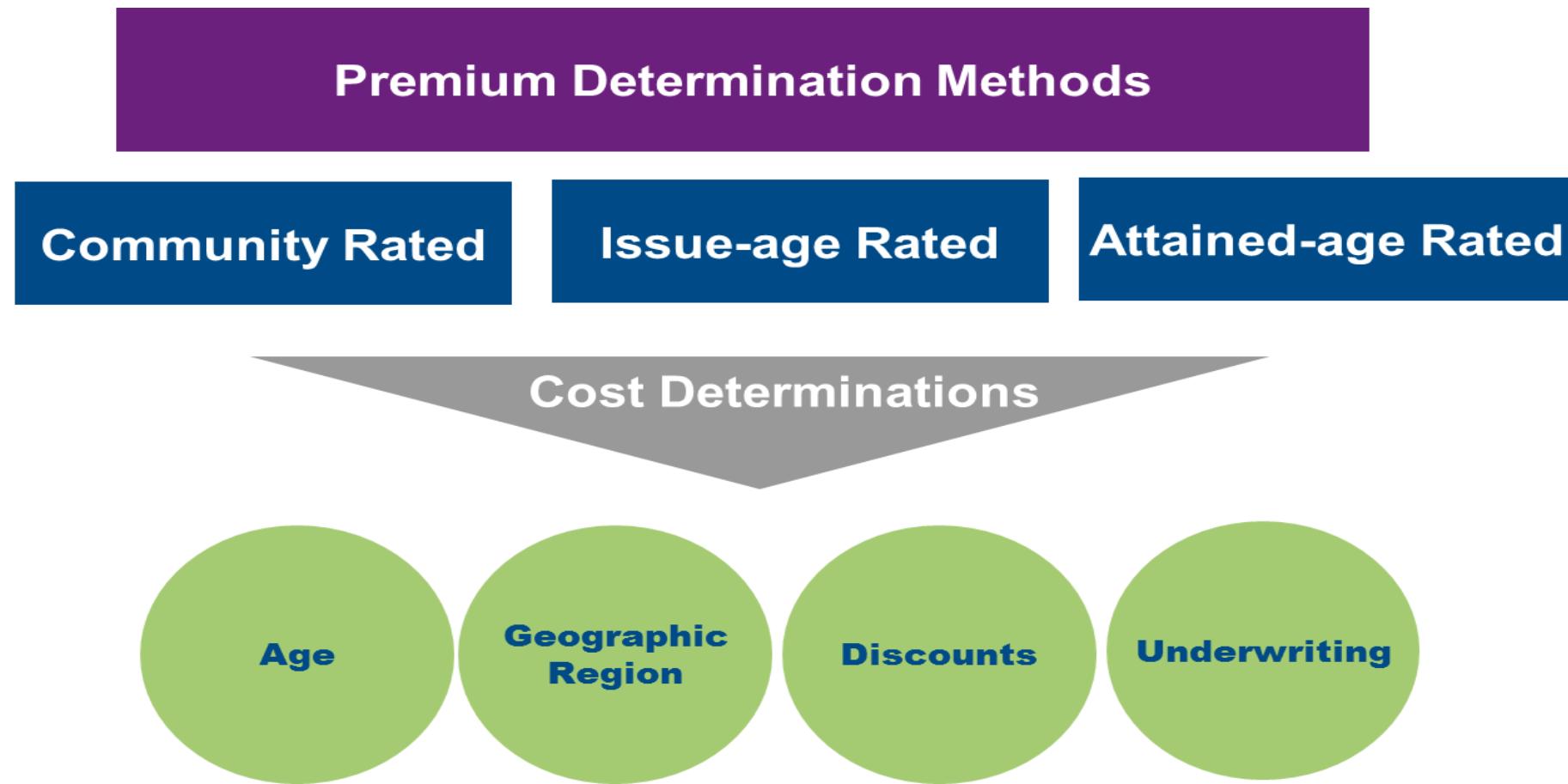
Premium Determination Methods

Community Rated

Issue-age Rated

Attained-age Rated

Premium Determination – Contd..



Medicare Premiums

Monthly premium for Part B

Determined based on income

Higher income = higher premium

Majority pay \$104.90

Late enrollment penalty is 10% for each year not enrolled in Part B

ID Cards

Medicare ID Card



Commercial ID Card

Insurance Company Name	Coverage Type
MEMBER NAME: ZACHARY PENDLETON MEMBER NUMBER: 130300002	EFFECTIVE DATE: 3/1/2012
GROUP #: C13G0001	PRESCRIPTION GROUP #: C13G
PCP CO-PAY: \$15.00 SPECIALIST CO-PAY: \$25.00 EMER. ROOM CO-PAY: \$75.00	PERSCRIPTION CO-PAY: GENERIC: \$15.00 NAME BRAND: \$25.00



Thank you



Healthcare Foundations

Benefits and Providers

Learning Services

Agenda

Benefits

- Identify the three out-of-pocket expense types
- Types of Medical Services

Providers

- Identify five provider types
- Provider Credentialing
- Contracting Process



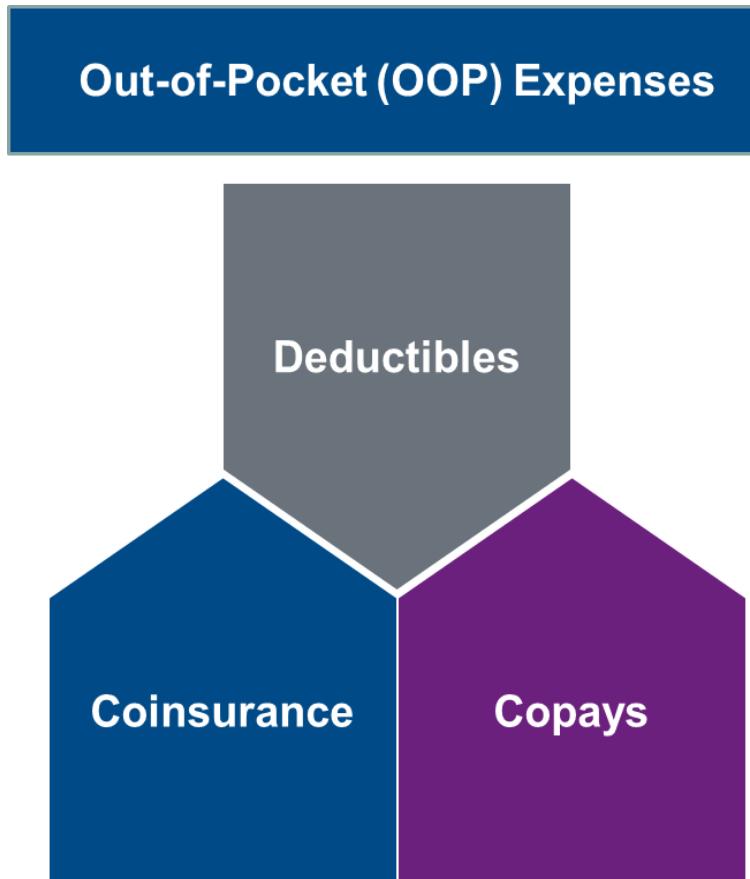
Benefits

Benefits

What are Benefits?

- Services covered by a member's health plan
- Common in a normal course of treatment
- Out-of-pocket expenses link to benefit types

Out-of-Pocket Expenses



Deductibles

Out-of-Pocket (OOP) Expenses

- Amount of out-of-pocket expense paid by member before plan pays
- Member pays 100% of plan-approved fee up to deductible amount



Deductibles

Coinsurance

Out-of-Pocket (OOP) Expenses



- Amount member pays to healthcare provider for medical services:
- Based on health plan's approved fee
- Plan pays a percentage
- Member pays remainder

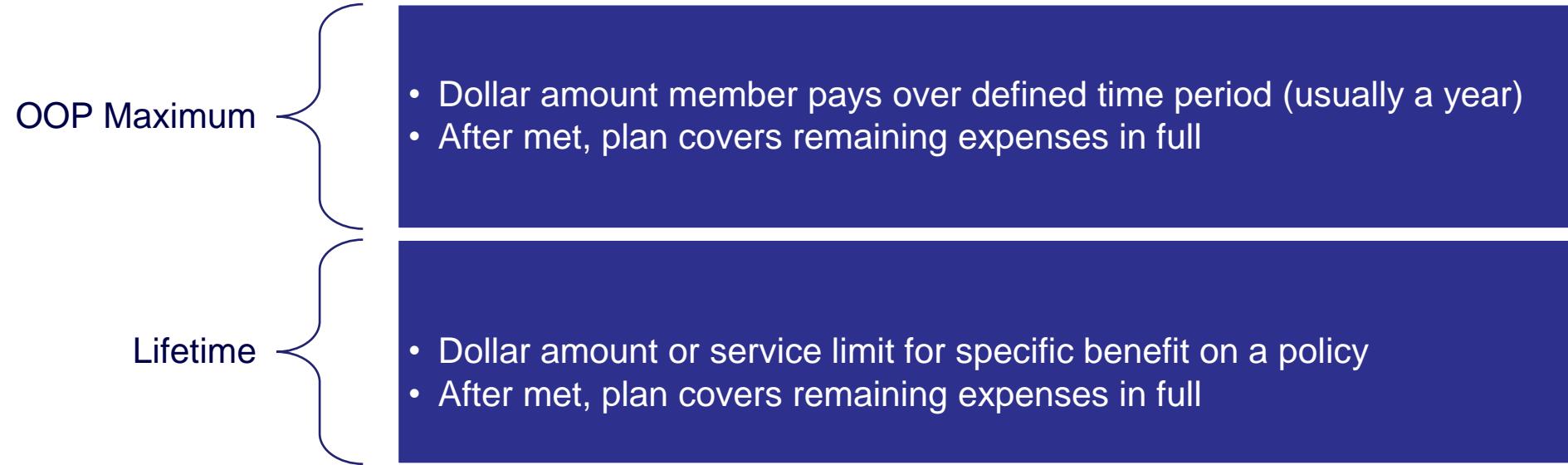
Copays

Out-of-Pocket (OOP) Expenses

- Fixed dollar amount paid by beneficiary
- Due at time of service
- Services such as office visits, chiropractic services, etc.



OOP Maximums



Preventive Care

Comprehensive care that emphasizes:

- Prevention
- Early detection
- Early treatment of conditions

Services include:

- Screenings
- Tests
- Vaccinations
- Routine exams
- Education

Medical Care

Comprised of medical outpatient services

Services include:

- Physician services
- Outpatient medical treatments
- Outpatient surgical services/supplies
- Diagnostic tests
- Ambulatory surgical facility fees

Hospital Care

Hospital services are delivered while inpatient in an acute care hospital

Services occur in:

- Critical access hospitals
- Inpatient rehabilitation facilities
- Long-term care hospitals
- Mental health facilities

Surgical Care

Services pertaining to surgical procedures

Performed in a variety of settings

- Place of service determines benefit level

Surgical service examples:

- Knee replacement (Inpatient)
- Open heart surgery (Inpatient)
- Hernia repair (Outpatient)
- Appendectomy (Inpatient)

Benefits split:

- Facility services
- Physician services

Durable Medical Equipment (DME)

Equipment for repeated use for a medical purpose

Examples of DME are:

- Hospital beds
- Walkers
- Wheelchairs
- Crutches
- Shower bench

Some items purchased – some rented

Pharmacy

Drugs or medicine provided by a pharmacy for use in medical treatment

Examples include:

- Self-administered drugs
- Injectable medication
- Oral chemotherapy
- Meds used with DME (e.g., nebulizer)

Home Healthcare

Short-term skilled care in the home or facility where member resides

Examples of services include:

- Medical social worker
- Part-time occasional skilled nursing care
- Physical therapy
- Speech-language therapy
- Occupational therapy

Hospice

Care provided to terminally ill patients in home, long term care, or inpatient facility

Member must qualify for services - Doctor must certify:

- Member is terminally ill
- Member is expected to live 6 months or less

Vision – Medical Benefit

Vision services for medical conditions:

- Glaucoma
- Conjunctivitis – (Pink eye)
- Eyeglasses/frames/contacts after cataract surgery

Not for services related to non-medical conditions:

- Nearsighted
- Farsighted
- Unless rider or add-on benefit available

Hearing – Medical Benefit

Hearing services for medical conditions

- Example: physical damage to the ear

No coverage for non-medical:

- Hearing loss
- Hearing aids
- Unless rider or add-on benefit available

Dental – Medical Benefit

Dental services related to a medical condition:

- Example: temporal-mandibular joint syndrome – TMJ

No coverage for non-medical dental services:

- Example: tooth decay

Coverage for dentures or routine dental care may be covered by member's dental insurance



Providers

Providers

Providers Defined...



Healthcare Professionals

and



Facilities

Providers

Providers Defined...

Healthcare Professionals

and

Facilities

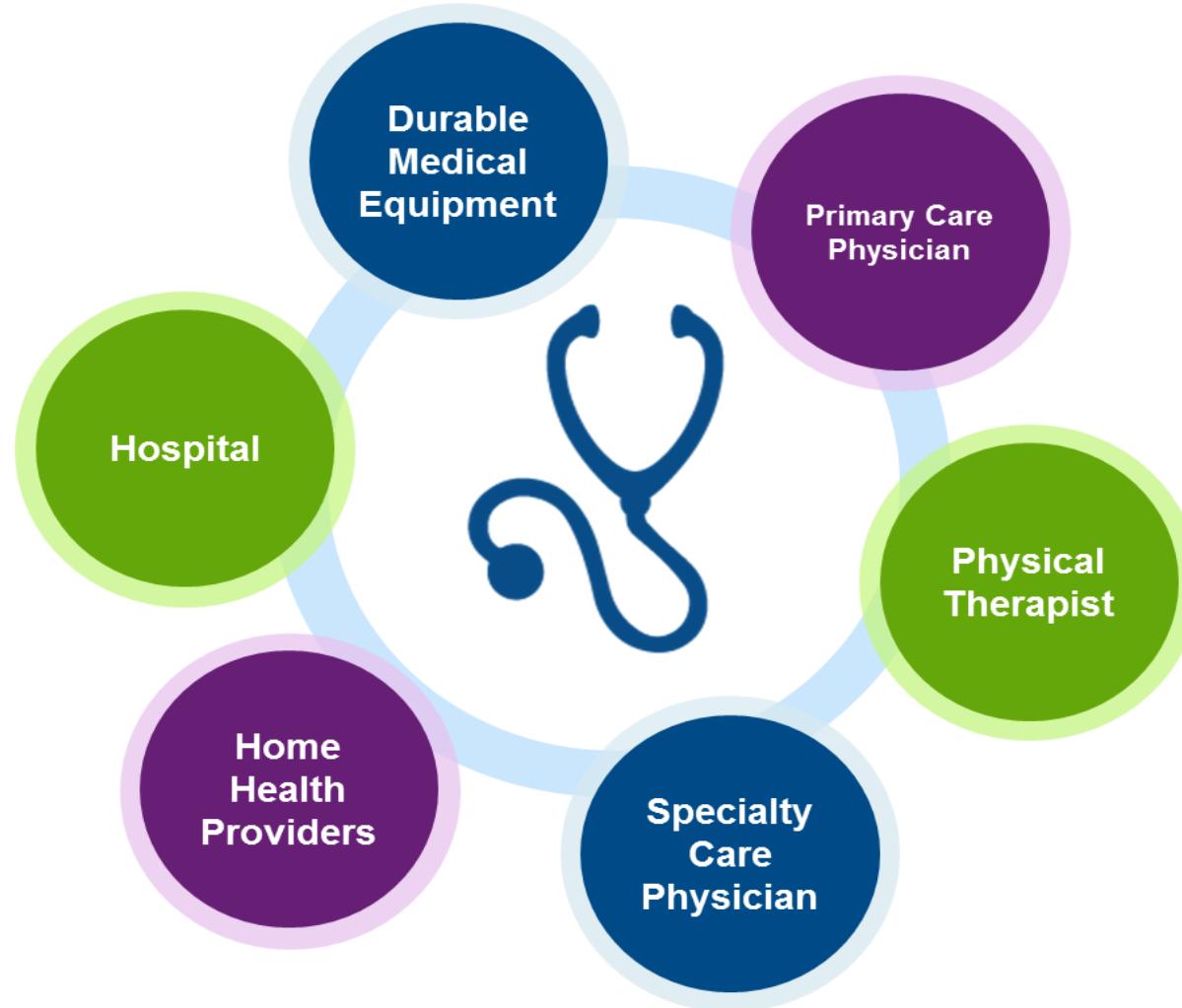
Providing services with expectation of payment



=



Providers



Provider Participation Process



Step 1



Step 2



Step 3



Step 4

**Provider
Interested in
Plan
Participation
or Recruited**



Provider Participation Process



Step 1

Provider
Interested in
Plan
Participation
or Recruited



Step 2

Credentialing
Process for
acceptance
in Plan



Step 3



Step 4



Provider Participation Process



Step 1



Step 2



Step 3



Step 4

**Provider
Interested in
Plan
Participation
or Recruited**

**Credentialing
Process for
acceptance
in Plan**

**Contracting
with Plan
Lines of
Business**



Provider Participation Process



Step 1

Provider Interested in Plan Participation or Recruited



Step 2

Credentialing Process for acceptance in Plan



Step 3

Contracting with Plan Lines of Business



Step 4

Participation with Payer Approved



Contracting

Contract participation hinges on credentialing approval.

Contract offered based on:

- Type of provider
- Contract participation type (HMO, PPO, Medicaid, Medicare)
- After contract signed, provider considered in-network, contracted provider

Networks

Groups of aligned providers

- Fee-for-service
 - Set fee for agreed upon services
- Capitated
 - Spreads risk
 - Increases exposure to patient population
 - Paid Per Member Per Month (PMPM) fee



Thank you



Healthcare Foundations

Introduction

Learning Services

Agenda

- Healthcare Terms
- Identify key events which shaped the current healthcare industry
- Identify two components of Medicare
- Recognize two components of Medicaid
- Identify two common plan models
- Identify two benefits of the Affordable Care Act as it relates to the uninsured population
- Identify two payer challenges of providing care to the aging population
- Identify correct descriptions of HIPAA and PHI

Introduction – Healthcare Terms

Member – The beneficiary who is enrolled with a Payer and receives the healthcare service.

Payer – Typically the health plan who manage the health care service and pay for the services

Provider – The medical practitioner, Hospital, Labs, Tertiary care services etc. that provides Health care Service

Sponsor (Billing Entity) – The entity who pays premium to Payer. Can be Employer Group, Individual family member etc..

Introduction – Healthcare Terms - Contd..



P – Payer

P – Patient

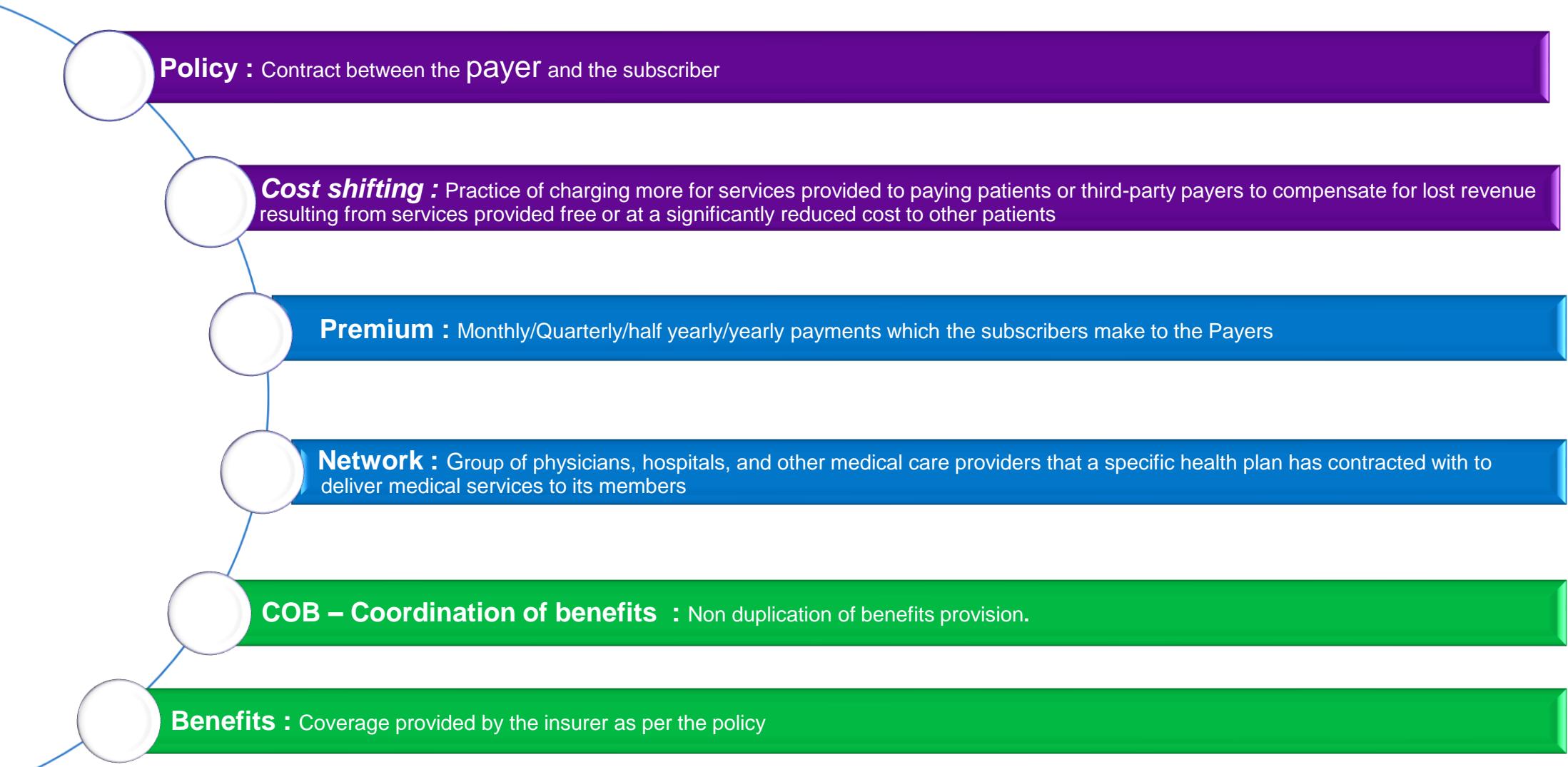
P – Provider

Payer – Insurance Company

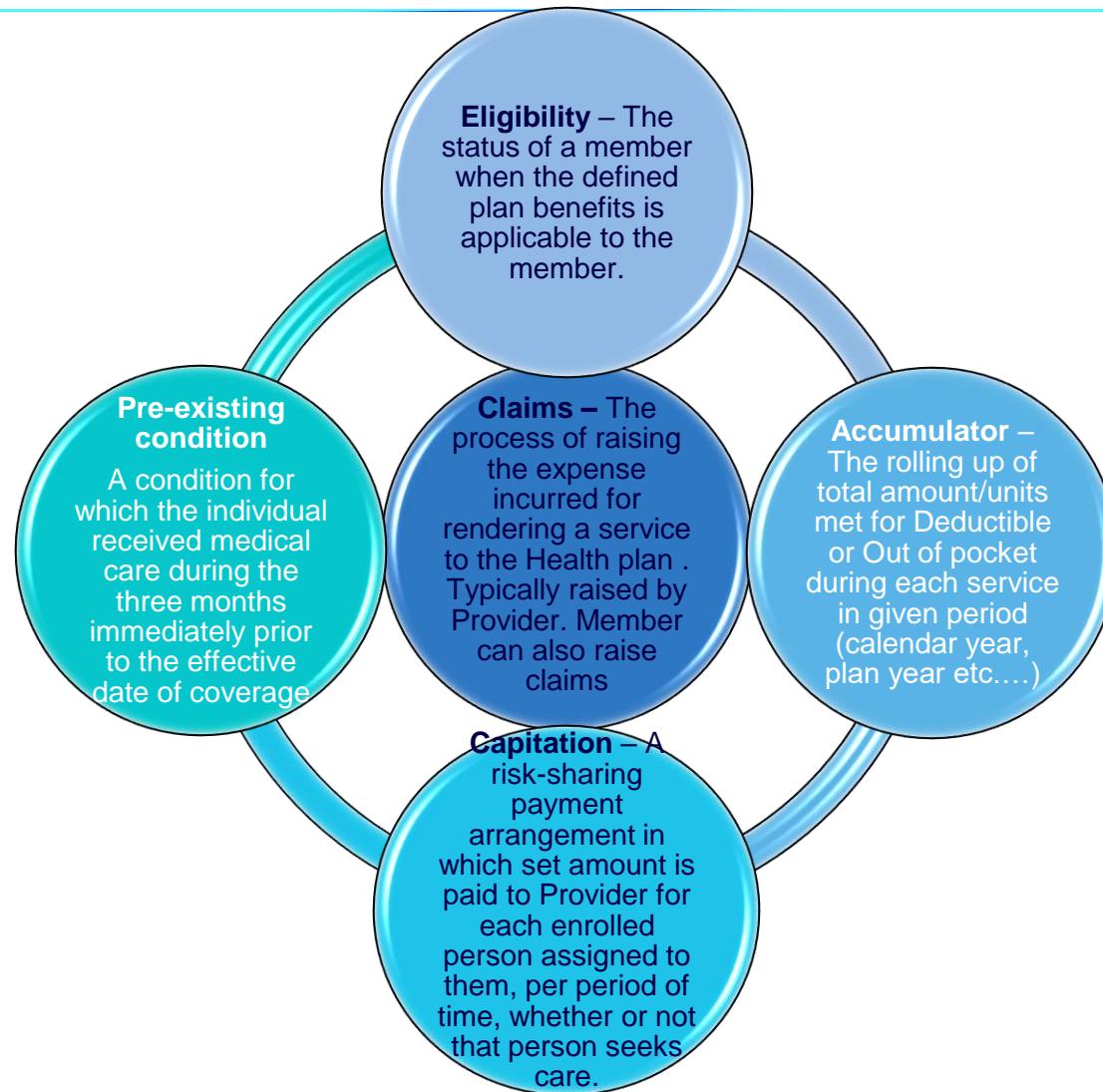
Patient – Subscriber, Member, Dependents

Provider – Physicians, Hospital , X-Ray Centre, Blood Bank, etc.,

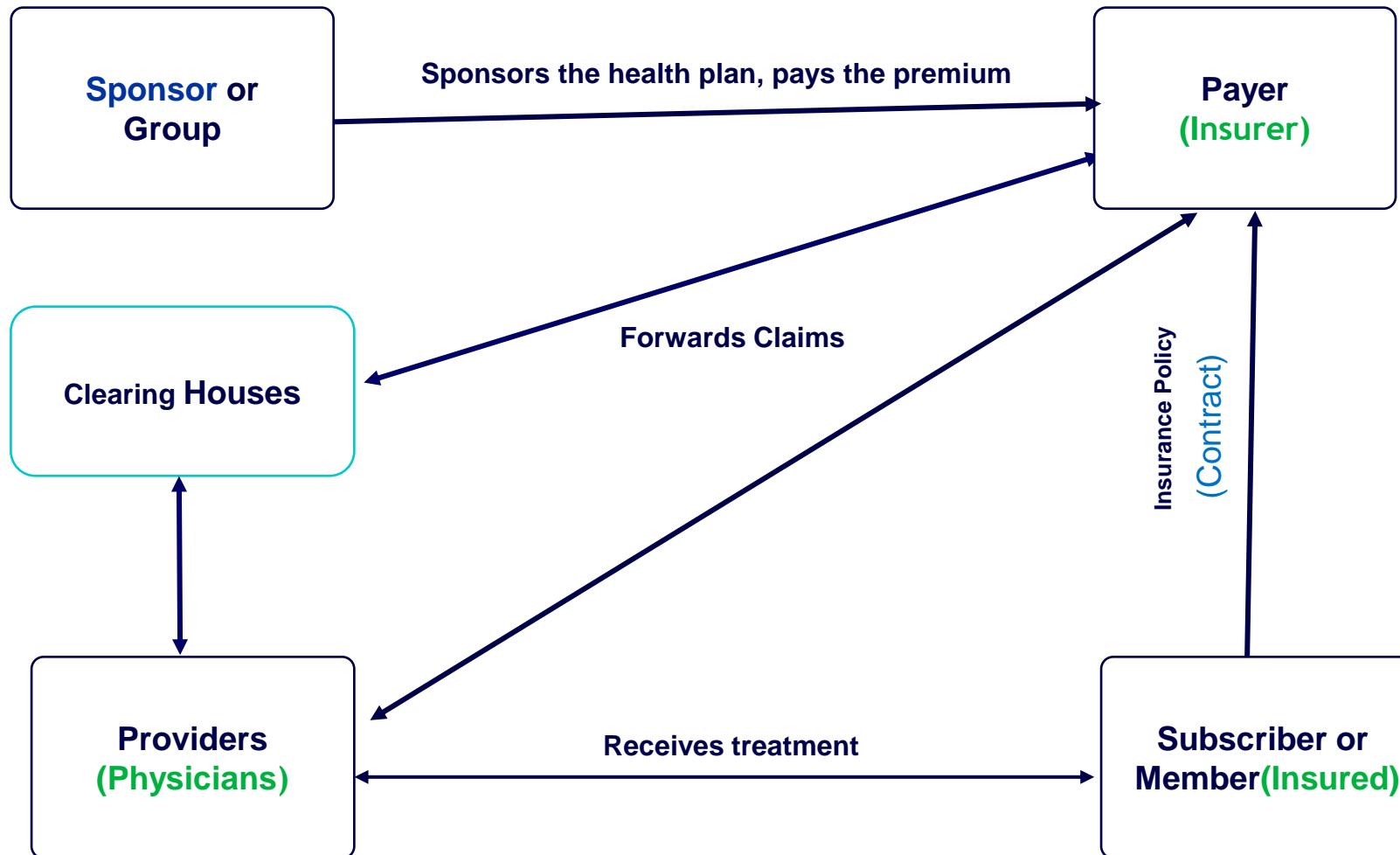
Key Terminologies & Definitions



Key Terminologies & Definitions - Contd..

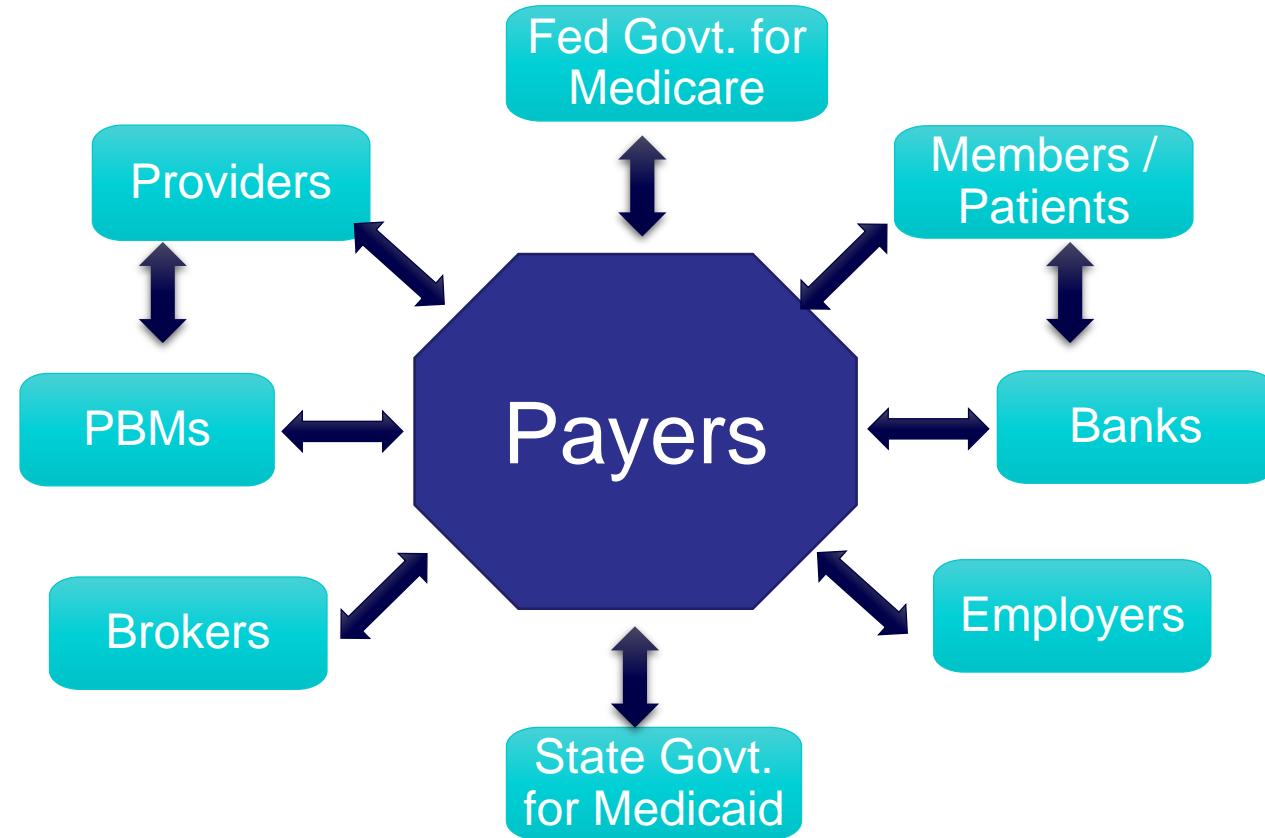


How are the Entities related ?

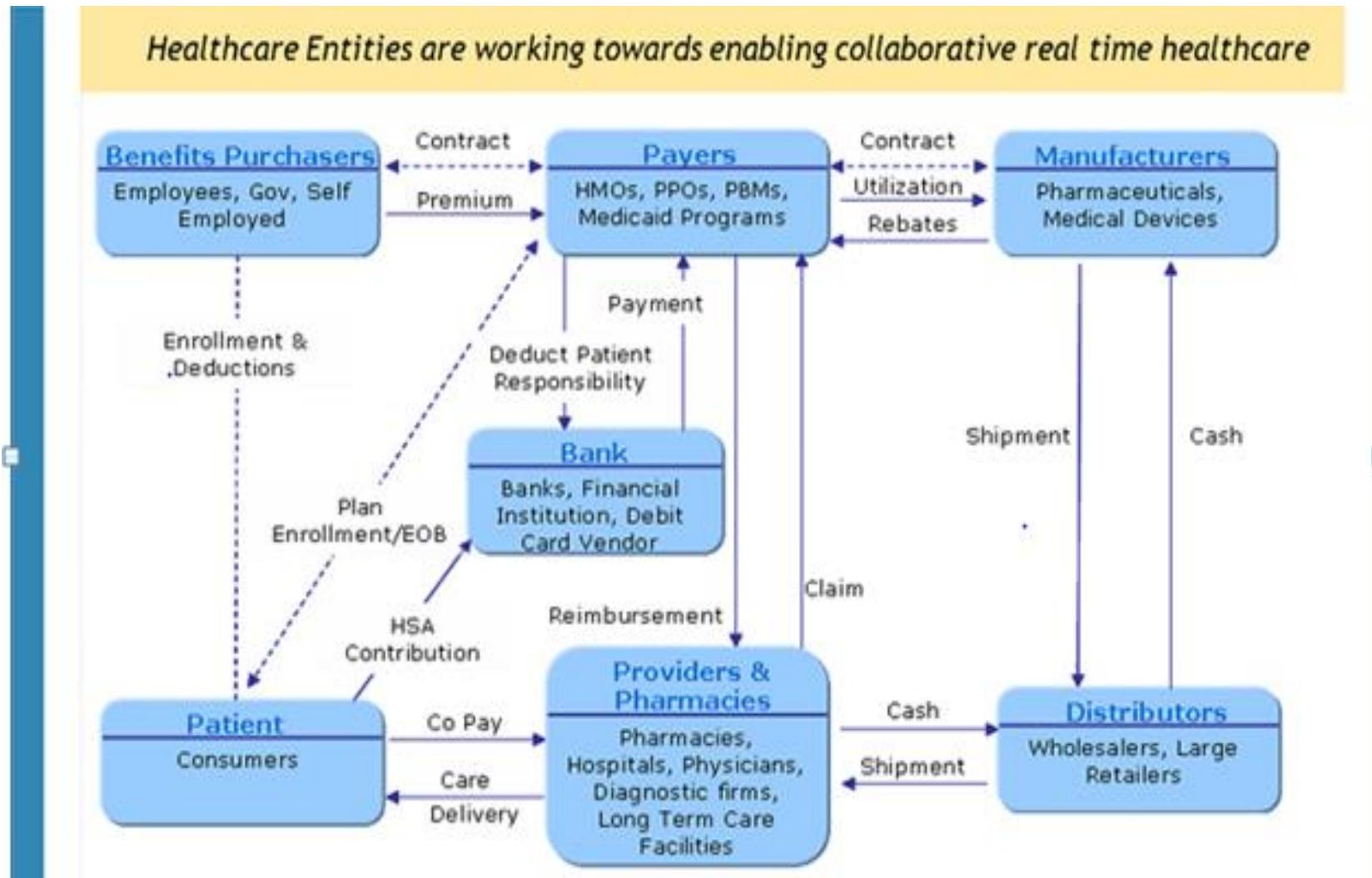


Healthcare Entities - Contd

Health Insurance – provides coverage for the financial expenses due to sickness, illness or accidents and they are issued either on individual or group basis.



Healthcare Ecosystem

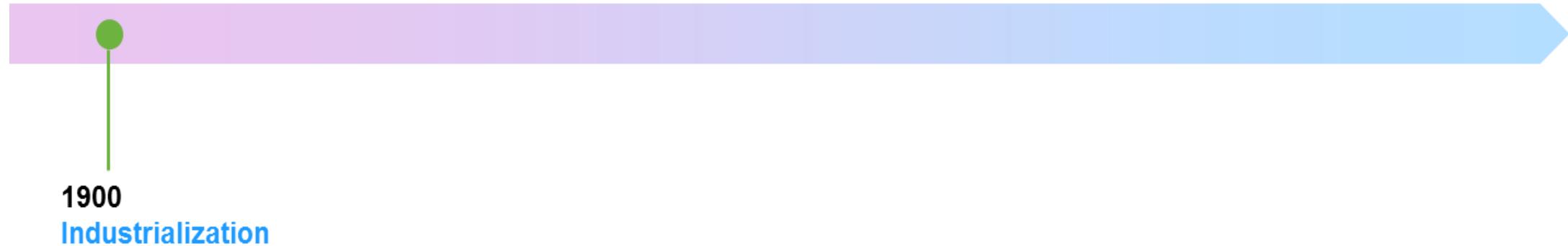


Evolution of US Healthcare

Industrialization



Need for Healthcare



Evolution of US Healthcare - Contd

The Great Depression



Healthcare Advances



Evolution of US Healthcare - Contd

Increased Costs



Healthcare Insurance

1920s

Great Depression



Evolution of US Healthcare – Contd..

Employment Benefits



Third-Party Payers

1920s

Great Depression

1940-1959

Employment Benefits



1900

Industrialization



1929-1939

Increased Costs



Evolution of US Healthcare - Contd

Medicare & Medicaid



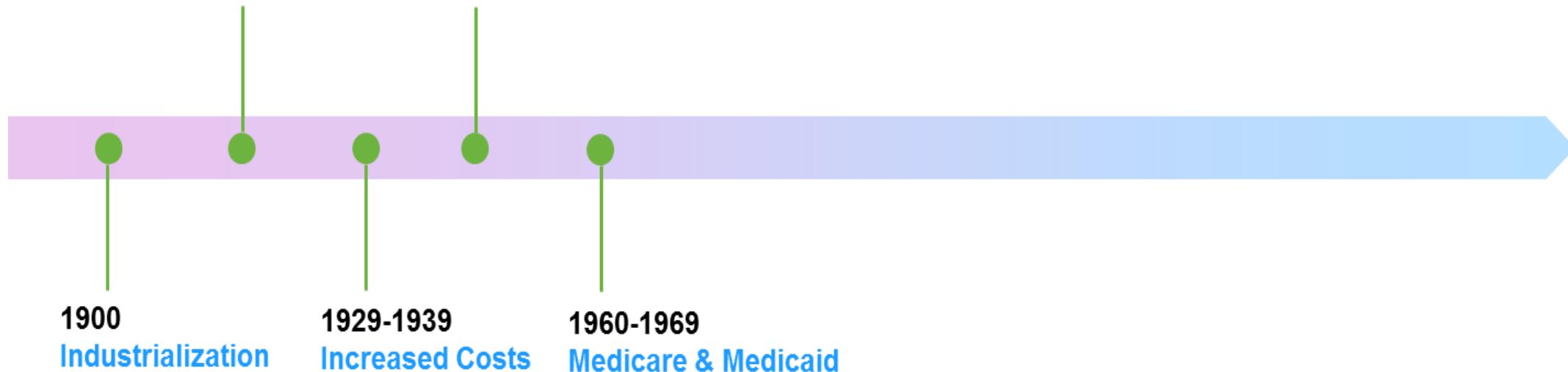
Government Programs

1920s

Great Depression

1940-1959

Employment Benefits

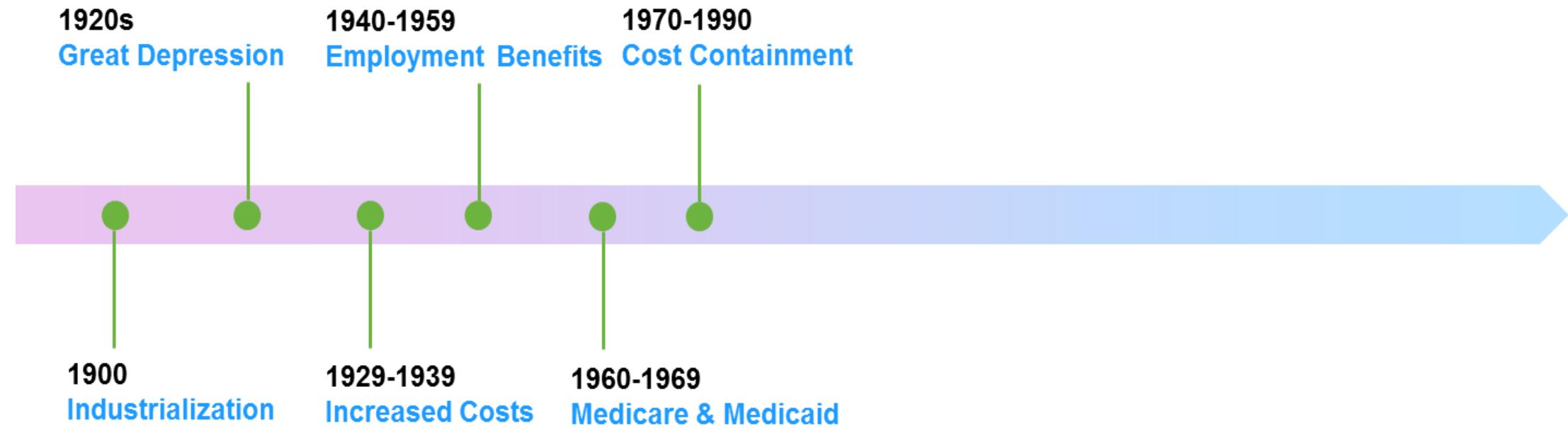


Evolution of US Healthcare - Contd

Cost Containment



Health Maintenance Organizations (HMO)



Evolution of US Healthcare - Contd

Patient Privacy & Advocacy



HIPAA & EDI

1920s
Great Depression

1940-1959
Employment Benefits

1970-1990
Cost Containment

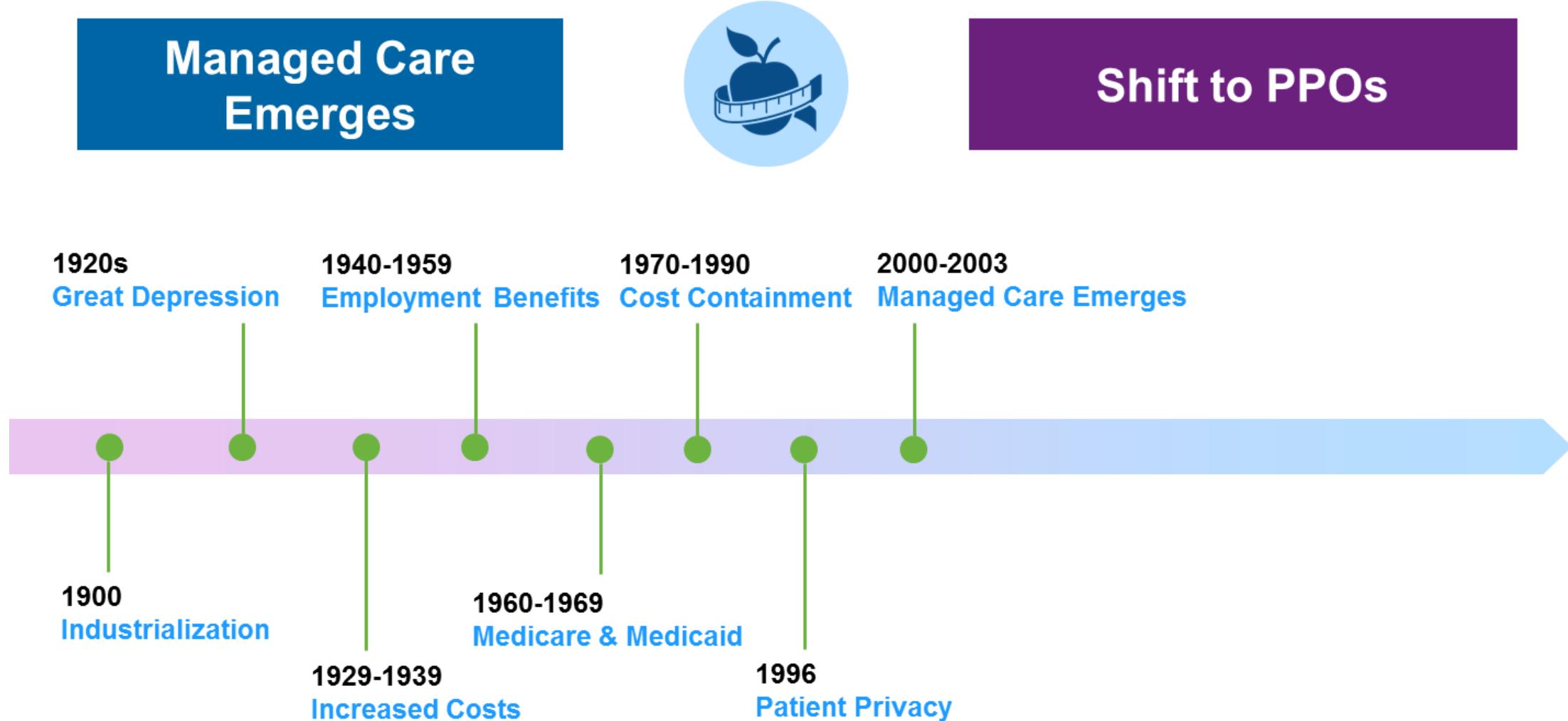
1900
Industrialization

1929-1939
Increased Costs

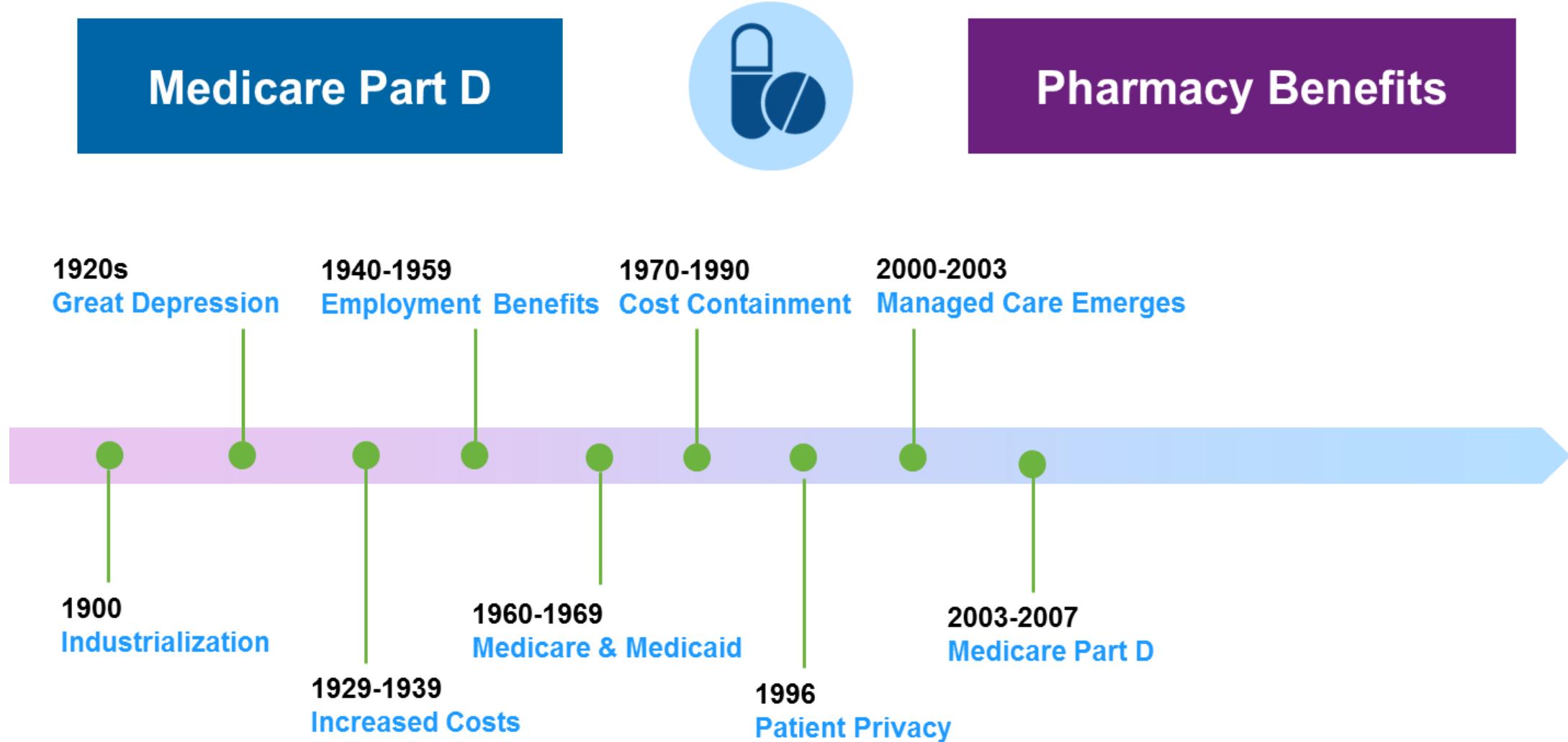
1960-1969
Medicare & Medicaid

1996
Patient Privacy

Evolution of US Healthcare - Contd



Evolution of US Healthcare - Contd

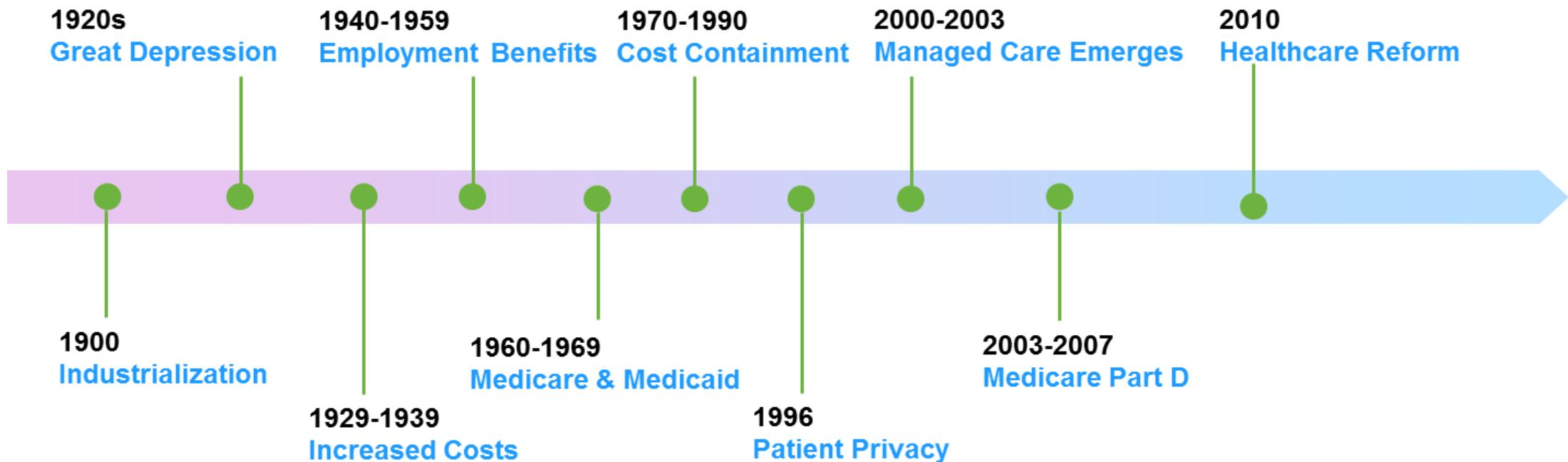


Evolution of US Healthcare - Contd

Healthcare Reform



Third-Party Expansion



Types of Health Insurance

Government Programs

- Medicare
- Medicaid

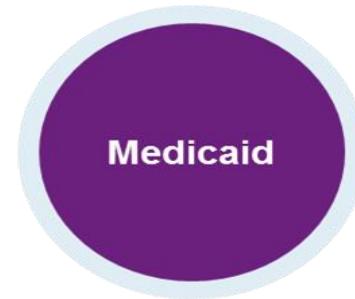
Commercial Plans

- Typically Employer-Sponsored
- Several Plan Models

Government Programs



- Federal Program
- Age 65 & Older
- Disabled
- ESRD



- State Program
- Income Based

Medicare & Medicaid:

- Federally Funded
- Similar Benefits

Medicare Funding

Medicare is funded by the following sources:

- General Revenue (Taxes)
- Payroll Taxes
- Premiums paid by Medicare Members
- State Funds
- Tax on Social Security Benefits
- Interest and other sources

Commercial Plans

Characteristics of Commercial Plans



Typically Employer Sponsored



Profit or Non-Profit Contract



Not Managed or Offered by Government



Sold by Brokers and Agents

Commercial Plans – Contd..

Characteristics of Commercial Plans



Typically Employer Sponsored



Profit or Non-Profit Contract



Not Managed or Offered by Government



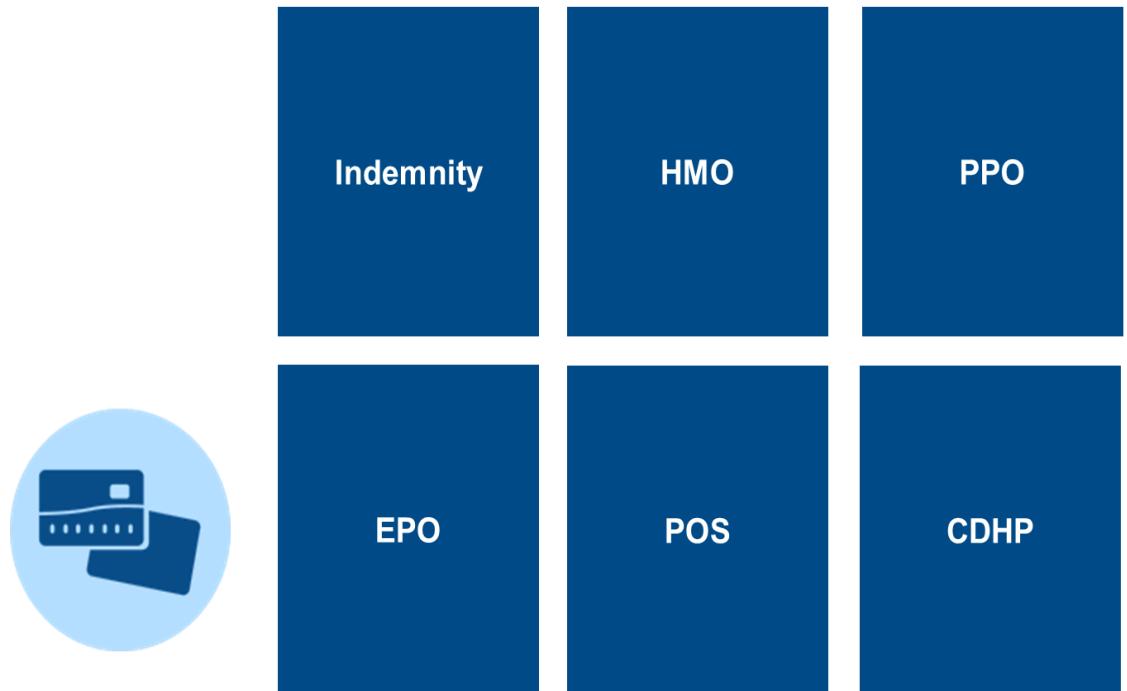
Sold by Brokers and Agents



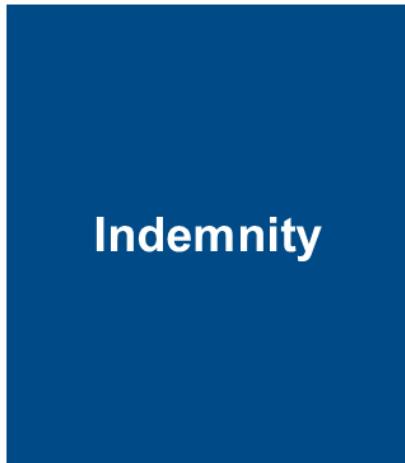
What are the common plan models?

Common Plan Models

Health Plan Models offer many options with varying levels of costs and control



Indemnity



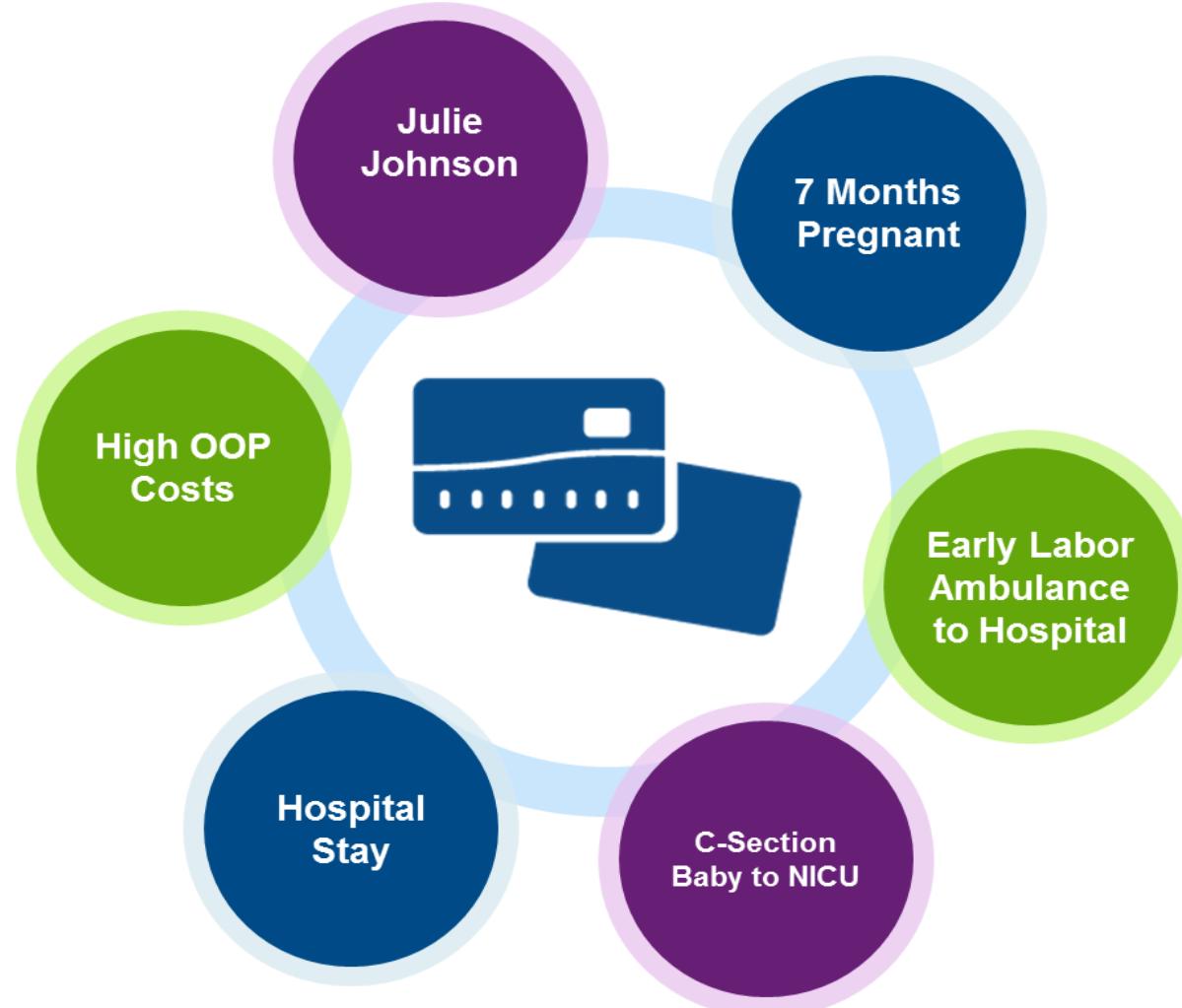
- Traditional Model
- Individual Directs Care
- No PCP
- Provider Paid FFS (Usual and Customary Charge)

Member has:

- More control
- High cost



Indemnity Example



Health Maintenance Organization (HMO)

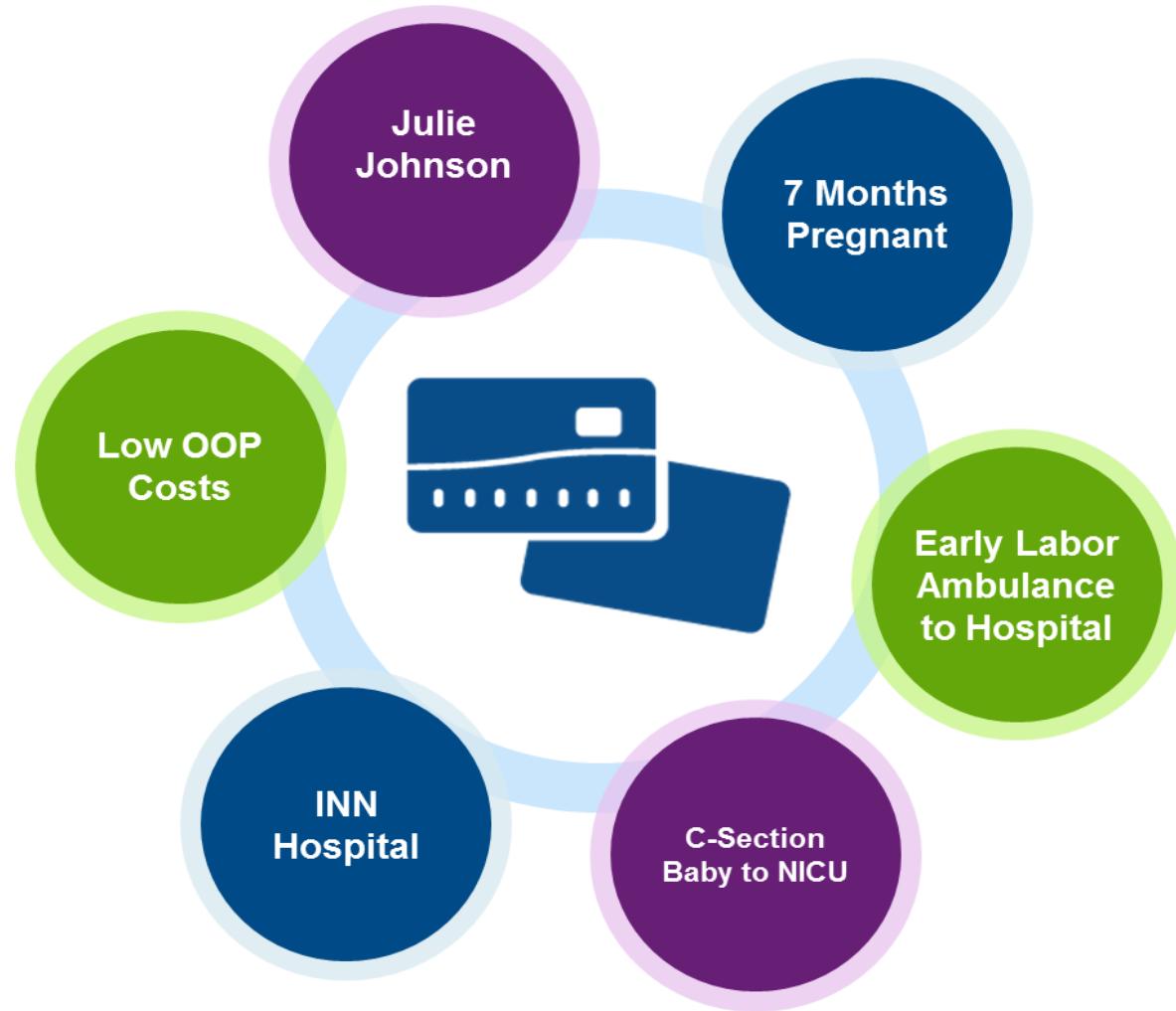


- Managed Care Model
- PCP Directs Care
- Provider Capitated

Member has:

- Less Control
- Lower OOP Costs

HMO Example



Preferred Provider Organization (PPO)

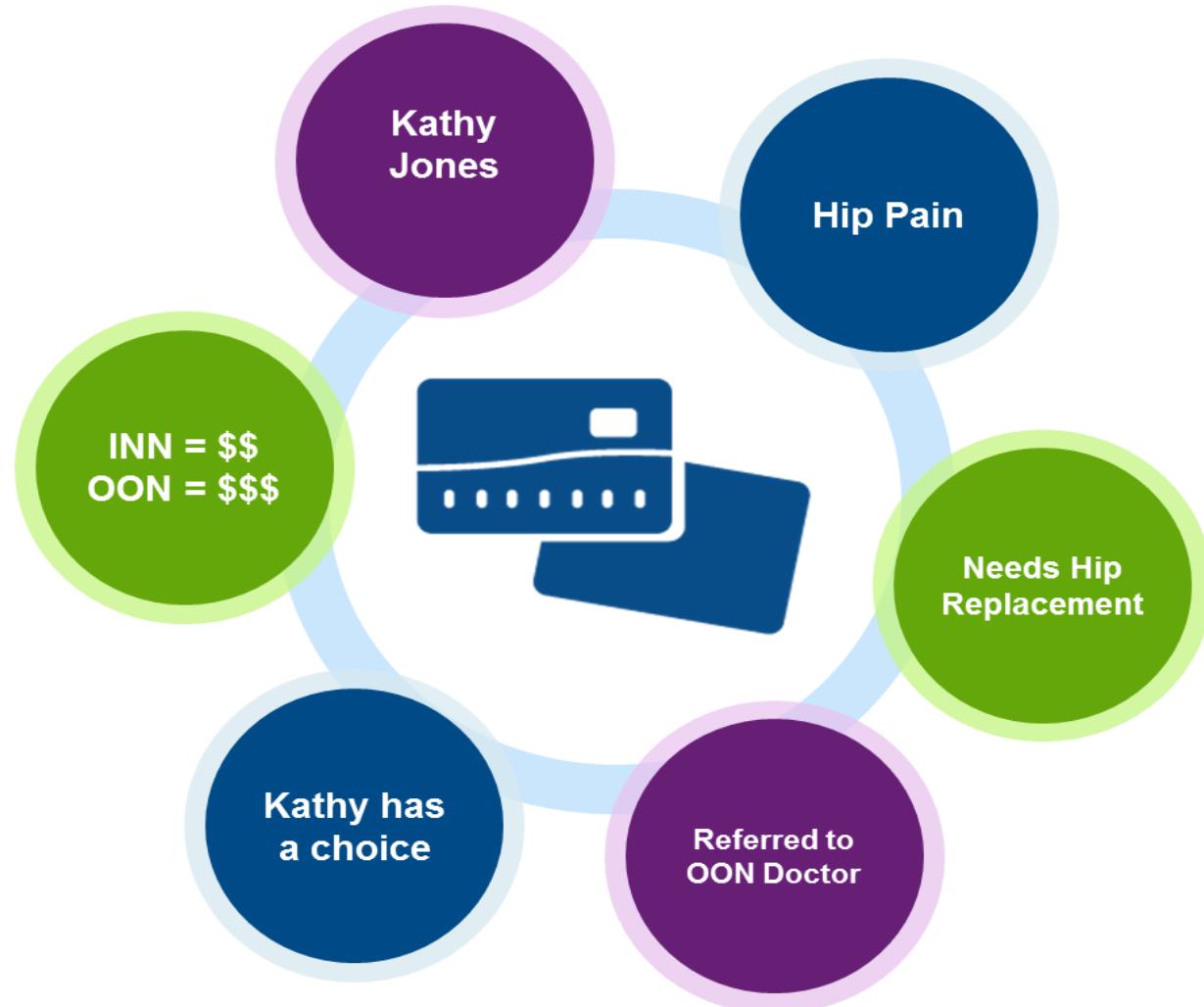


- Common Model
- INN and OON Benefits
- Provider Paid FFS (Discounted Compensation)

Member has:

- Moderate Control
- Low INN OOP

PPO Example



Exclusive Provider Organization (EPO)



- Mix of HMO and PPO
- Smaller network
- Provider Paid FFS



Member has:

- Less Control
- No OON Benefits

Point of Service (POS)



- Two Benefit Levels
- Open Access Plan
- Provider Paid FFS or Cap

Member has:

- Moderate Control
- OON and INN Benefits

POS Plan Example

If member sees PCP:

- HMO criteria used

If member sees OON provider

- Indemnity guidelines/OON benefit used

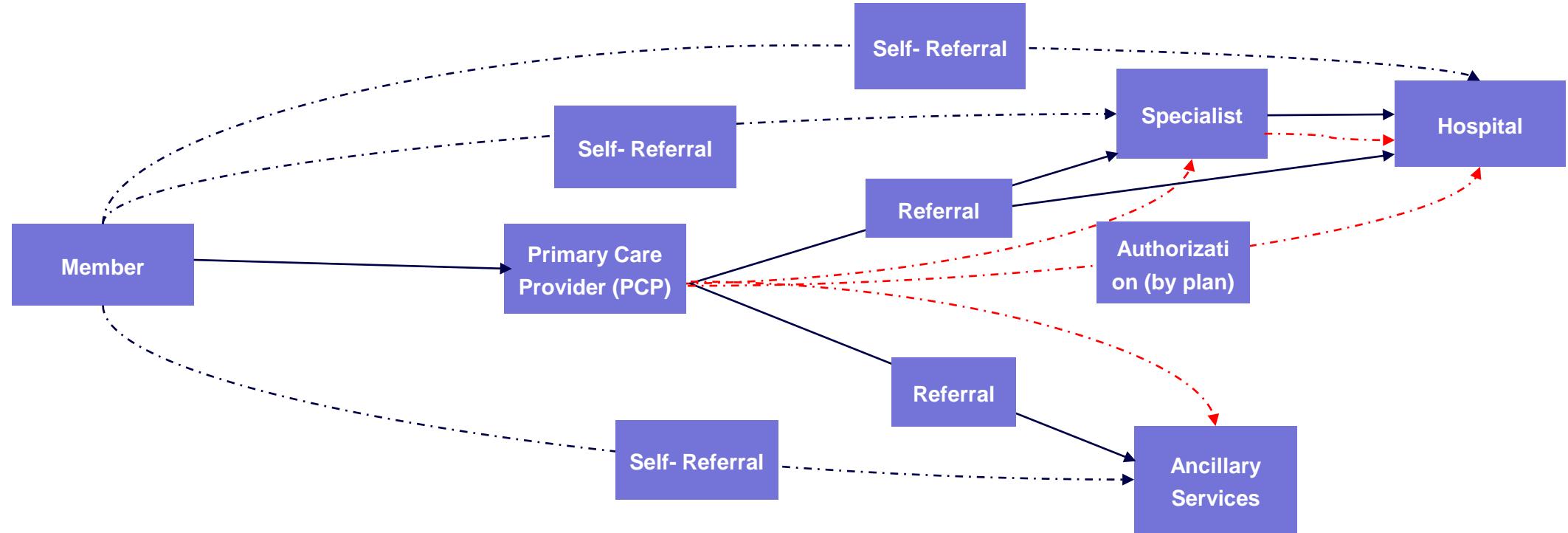
Members make own decisions:

- Need greater understanding of financial consequences

Comparison of Managed Care Entities

Constraint	Indemnity	HMO	PPO	POS
PCP	Not Required	Required	Not Required	Required
Deductible	Required	Not Required	In-network : Not Required Out-of-network: Required	Same as PPO
Out of Network Coverage	Available	Not Available	Available	Available
Referral for Specialist Visit	Not Required	Required	Not Required	Required
Cost (1-5) 5 is max	5	1	4	3
Freedom (1-5) 5 is max	5	1	4	3

Typical Managed Care Scenario



Consumer-Driven Health Plan (CDHP)



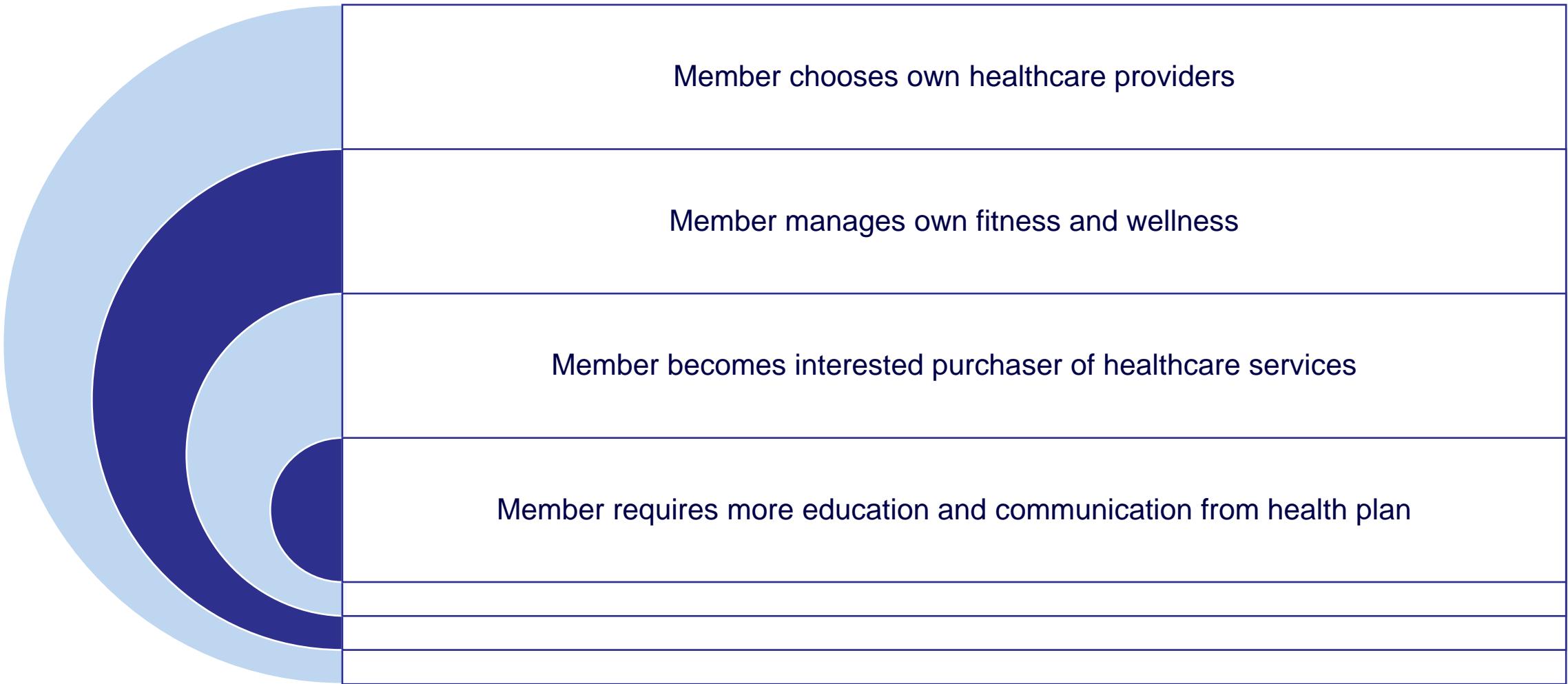
- Low Premium
- High Deductible Plan
- Provider Paid FFS

Member has...

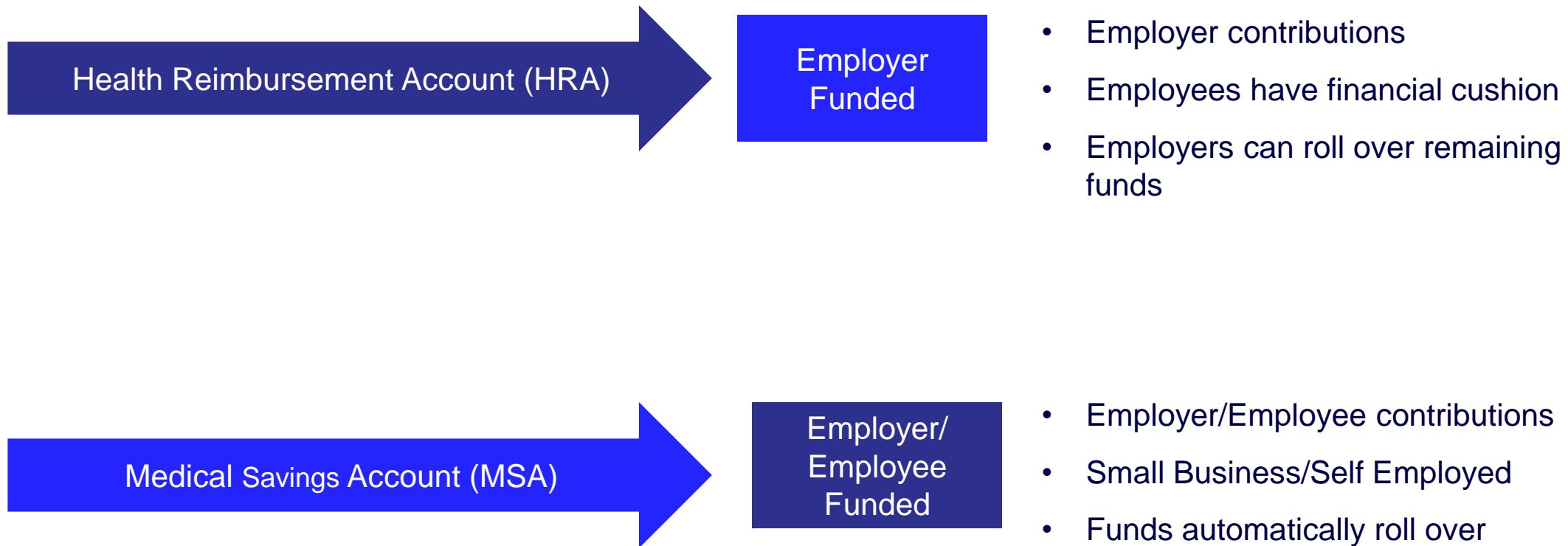


- High Control
- High OOP

CDHP Example



CDHP Related Accounts



HRA Example 1

Steven Sails, Employee of Moss Inc.

- Moss, Inc. offers HDHP
- \$2500.00 deductible – 90% coinsurance
- Preventive care – 100%
- Employer contributes \$1000 into HRA for each employee

Annual physical

- \$300.00 cost
- Covered at 100%

HRA Example 2

Steven had accident – broken arm

- Hospital ER
- Cost for ER visit/treatment: \$3000

Summary of payment:

- Deductible \$2500.00
- Remaining \$500.00 – 90% coinsurance

Steven's responsibility:

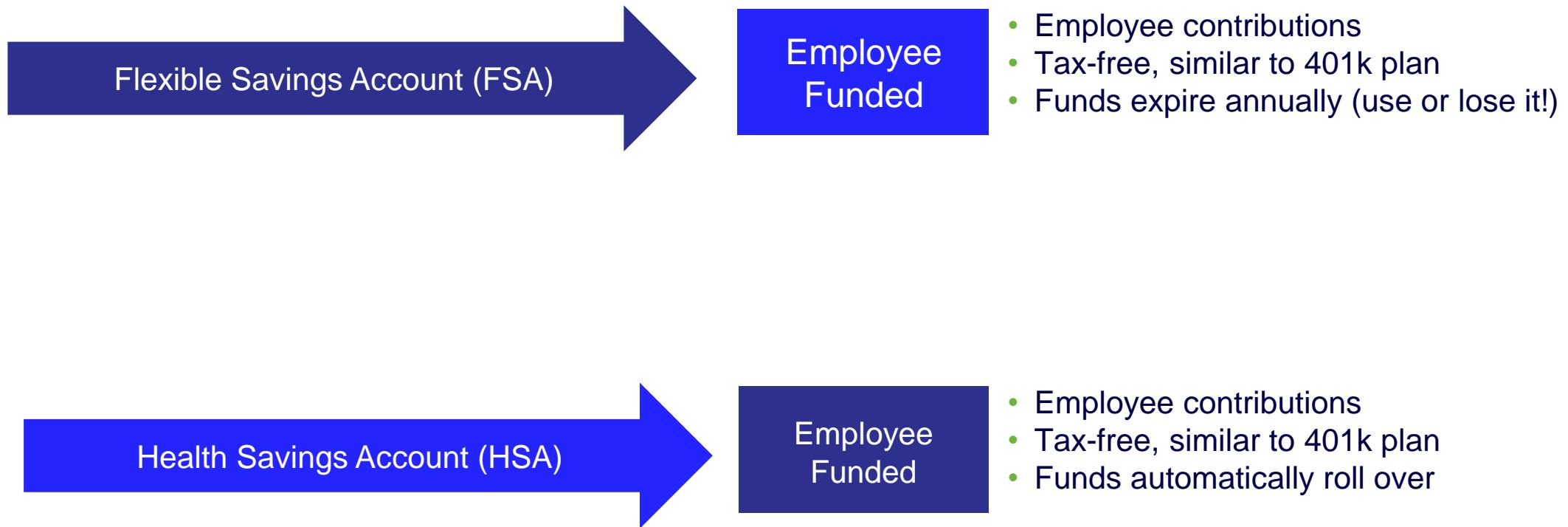
- $\$2500.00 + \$50.00 = \$2550.00$

Employer-funded HRA pays:

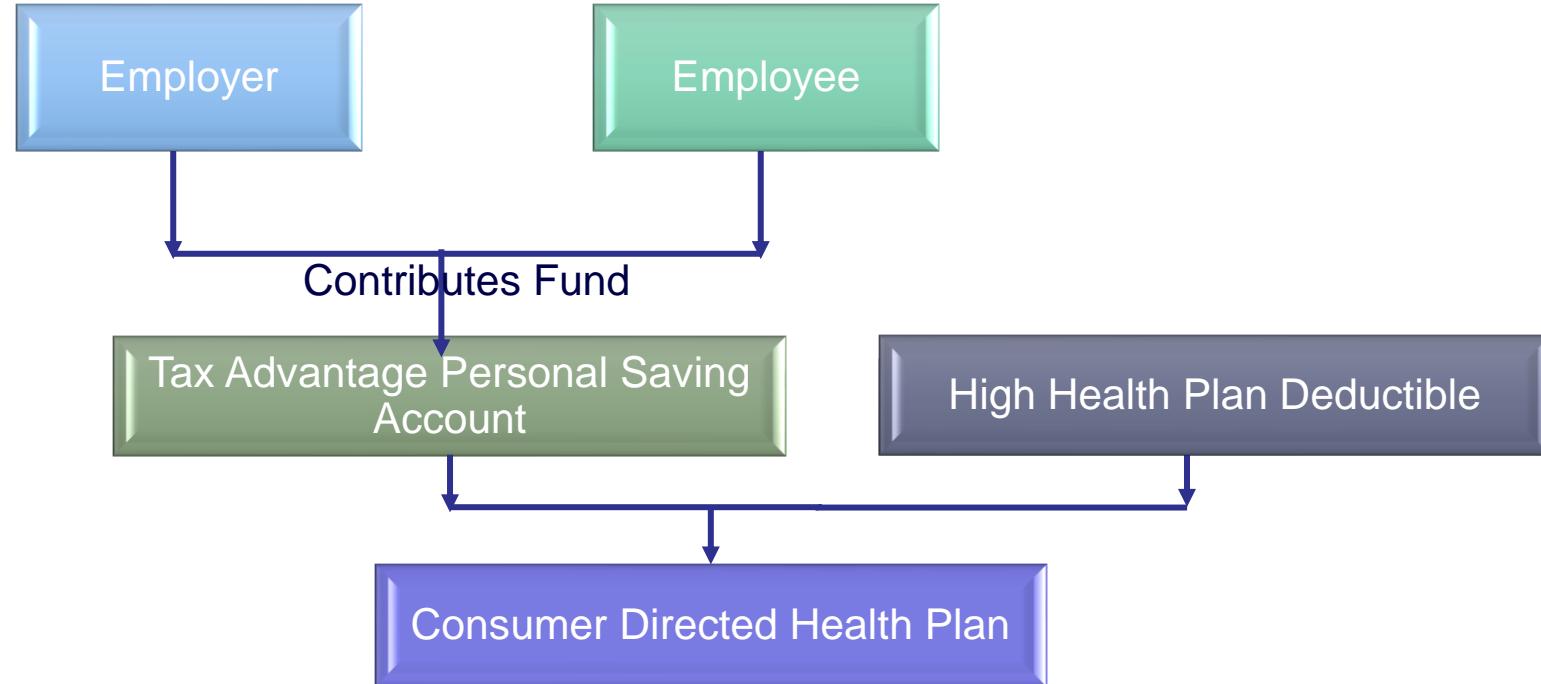
- \$1000.00

Steven's OOP: \$1550.00

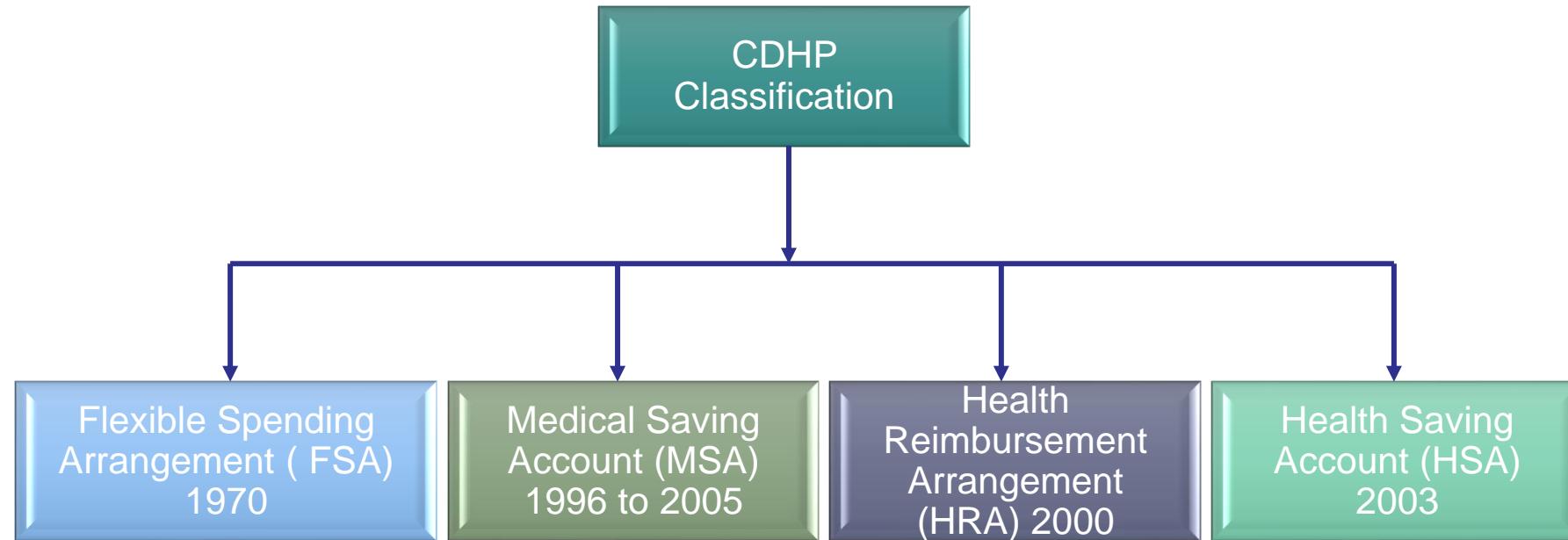
Pre-tax Medical Expense Account



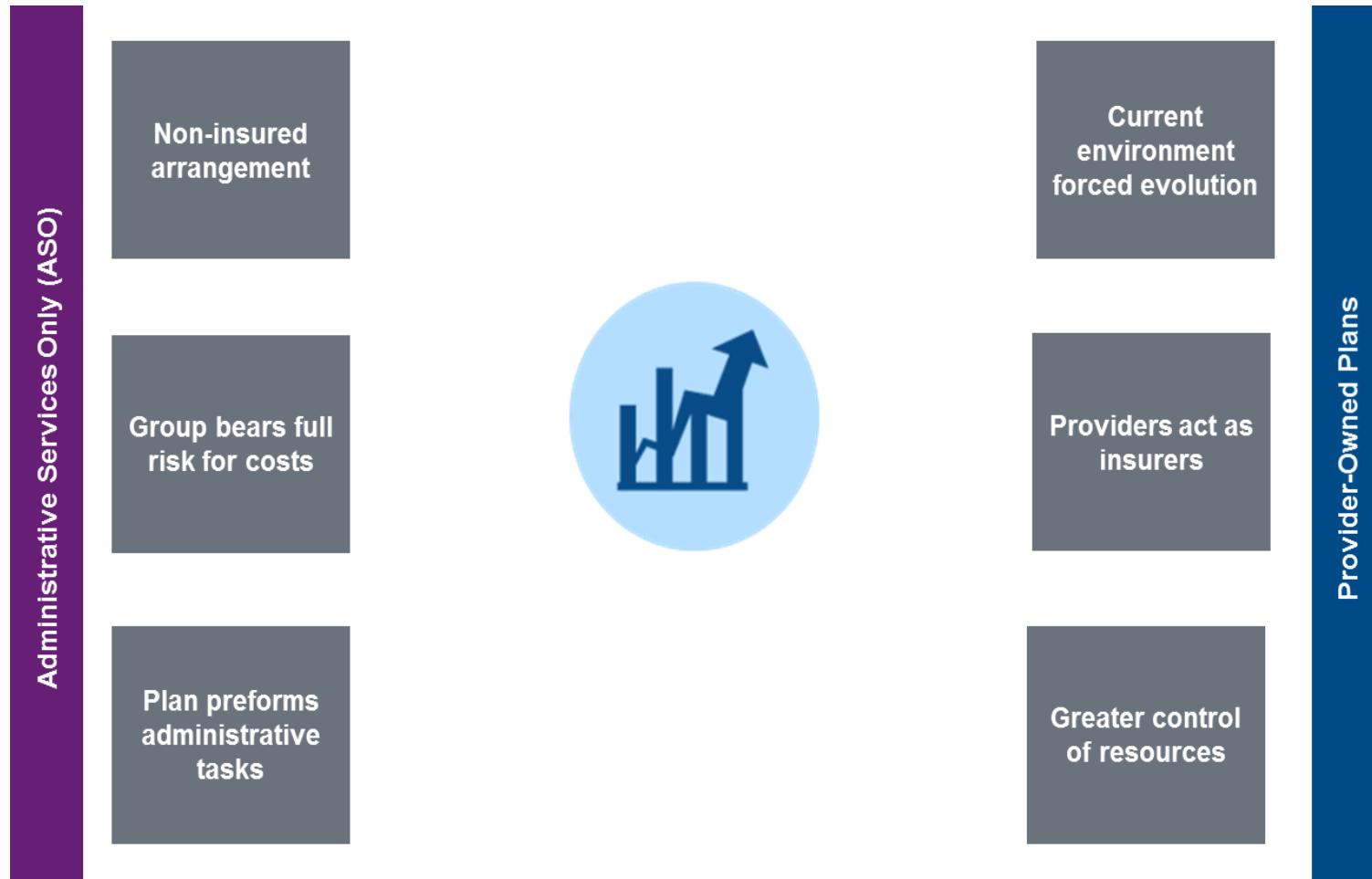
Formation of CDHP



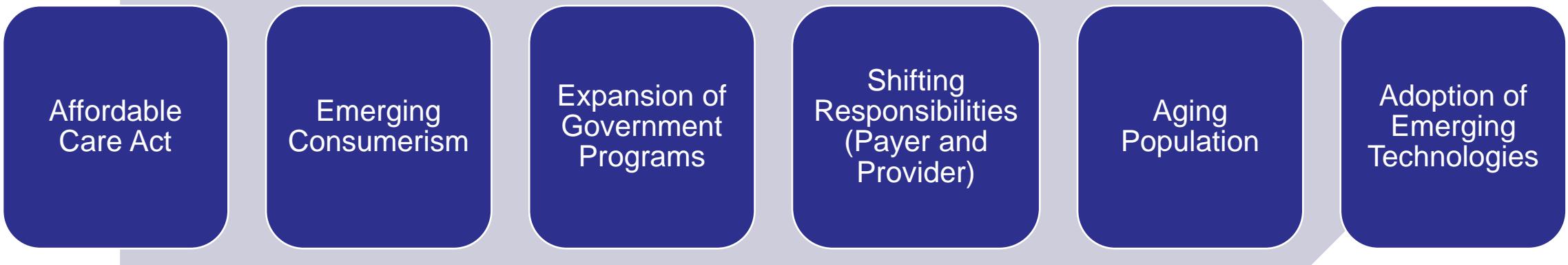
Formation of CDHP



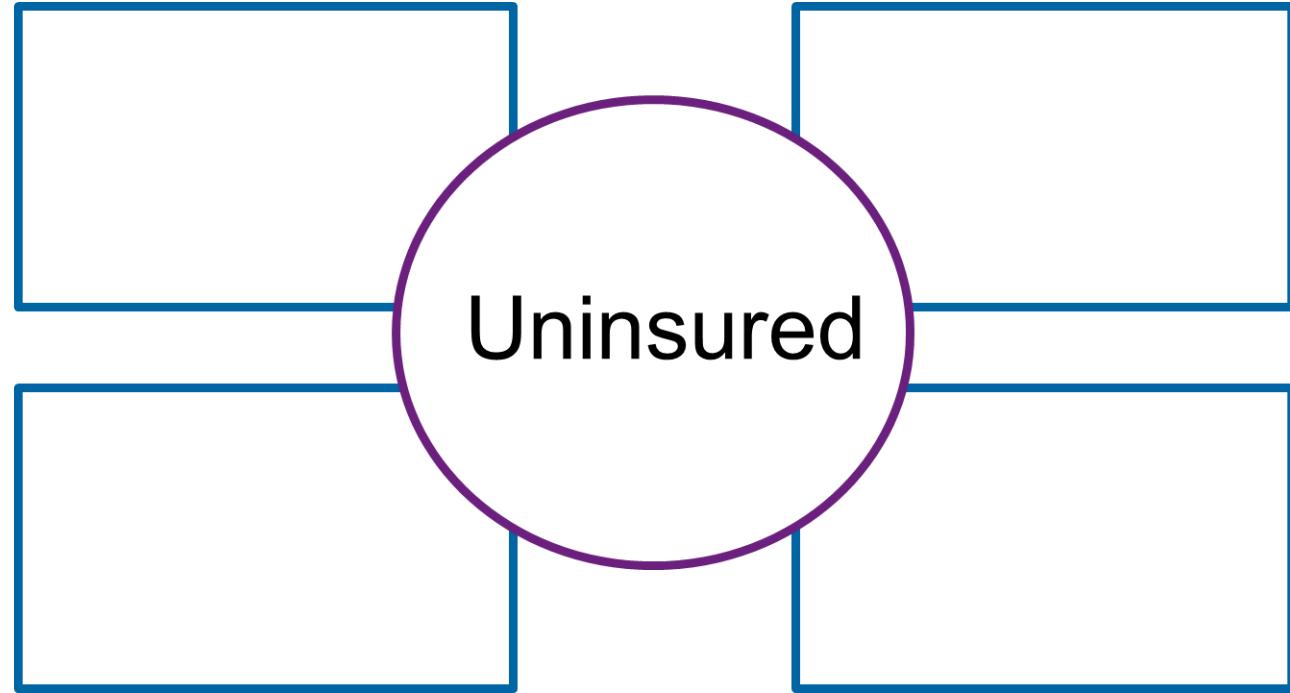
Trending...ASO and Provider-Owned Plans



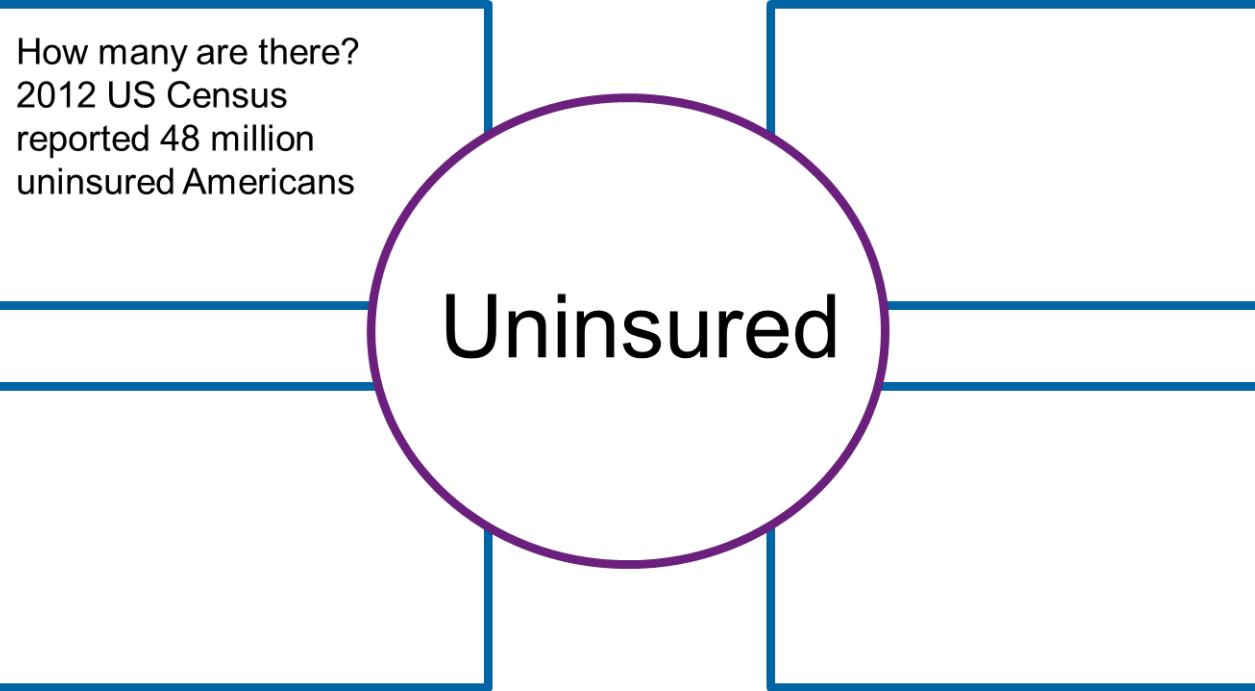
Current Trends



Uninsured



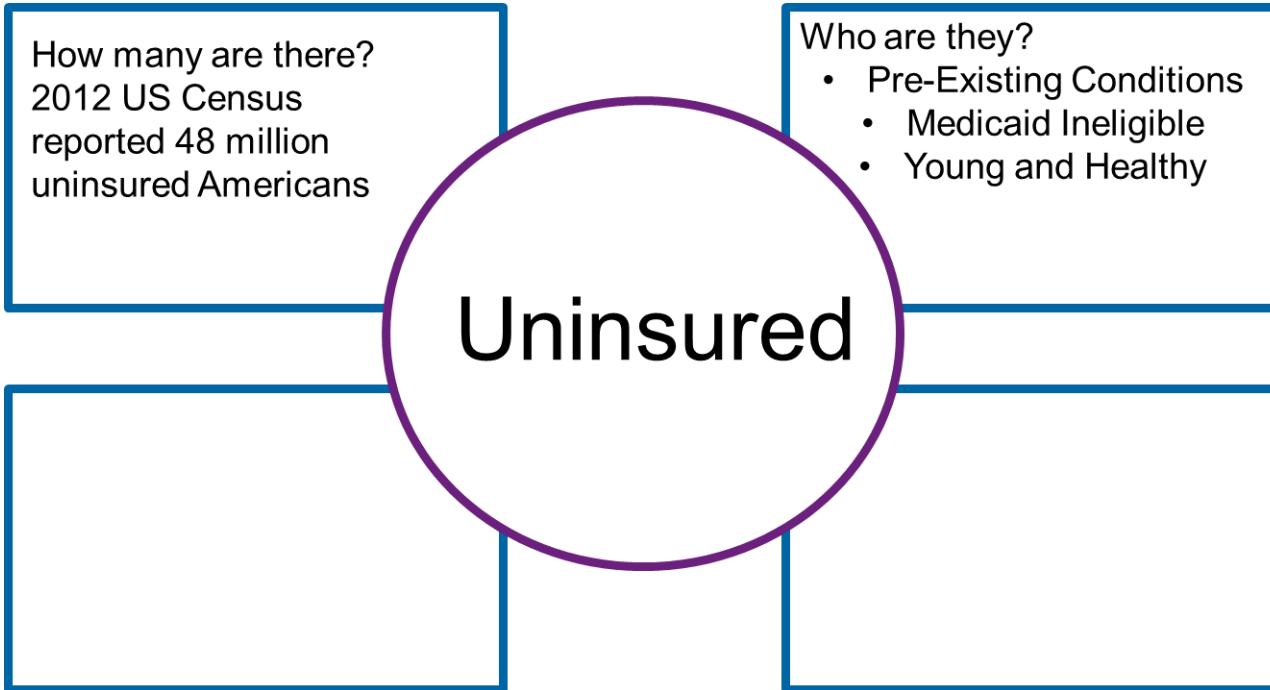
Uninsured



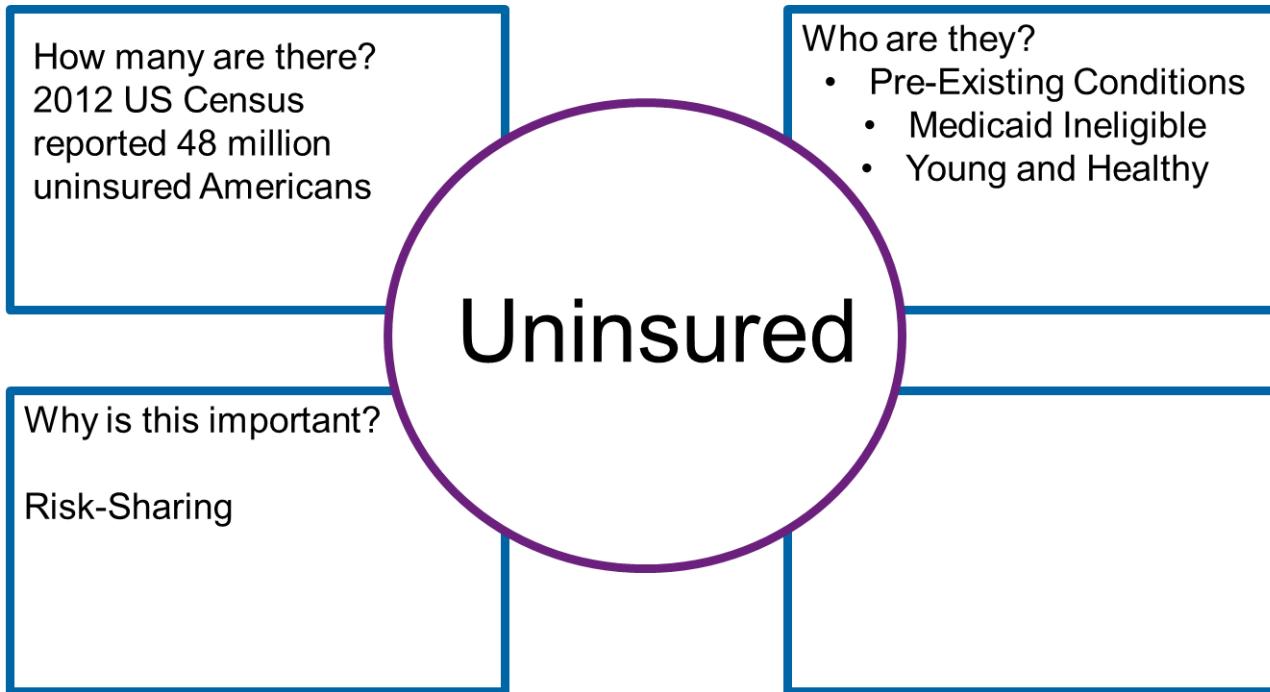
How many are there?
2012 US Census
reported 48 million
uninsured Americans

Uninsured

Uninsured



Uninsured



Uninsured

How many are there?
2012 US Census
reported 48 million
uninsured Americans

Who are they?
• Pre-Existing Conditions
• Medicaid Ineligible
• Young and Healthy

Why is this important?
Risk-Sharing

What is Risk-Sharing?
Young and healthy offset
costs of aging or sick
population in the risk pool

Uninsured

Affordable Care Act

Expansion of Medicare

Adults below 133% of Federal Poverty Line

Affordable Care Act

Expansion of Medicaid

Adults below 138% of Federal Poverty Line

Family Size	Annual Income
1	\$16,242
2	\$21,983
3	\$27,724
4	\$33,465
5	\$39,205
6	\$44,946
7	\$50,687
8	\$56,428

Source: Medicaid 2016 Poverty Guidelines

Affordable Care Act

Subsidies and Employer Tax Credits

Tax Credits



Decrease Premium

Increase quality and affordability of health insurance
Lower the number of the uninsured
Expand public and private healthcare insurance

Cost Sharing

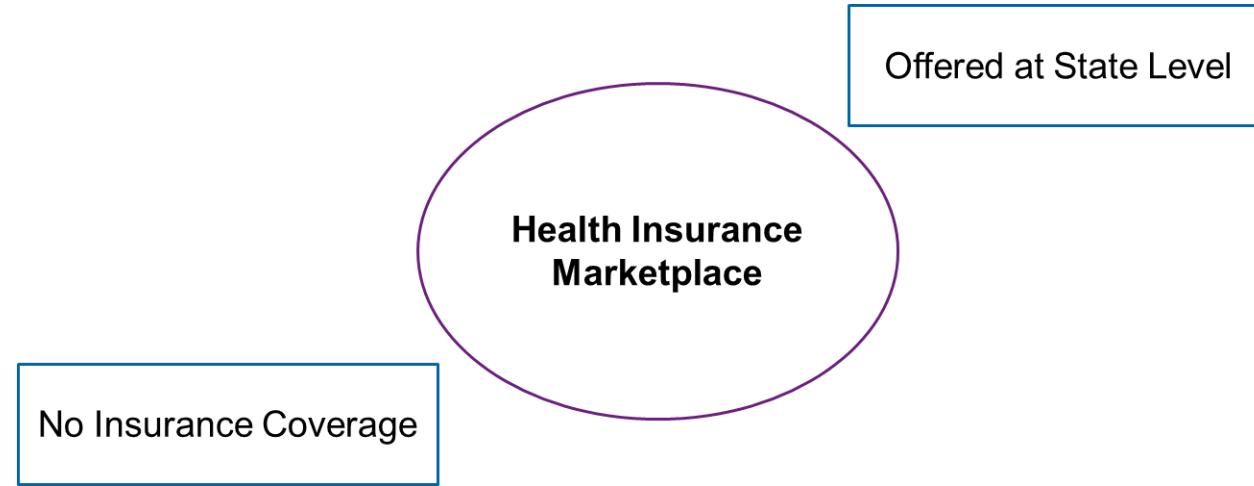


Out of Pocket Costs

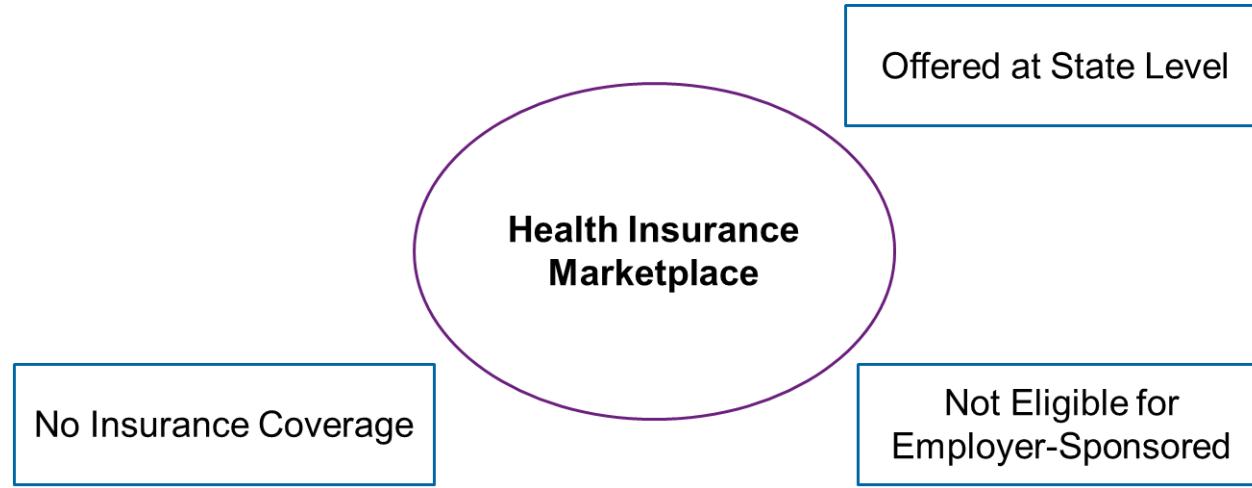
Affordable Care Act



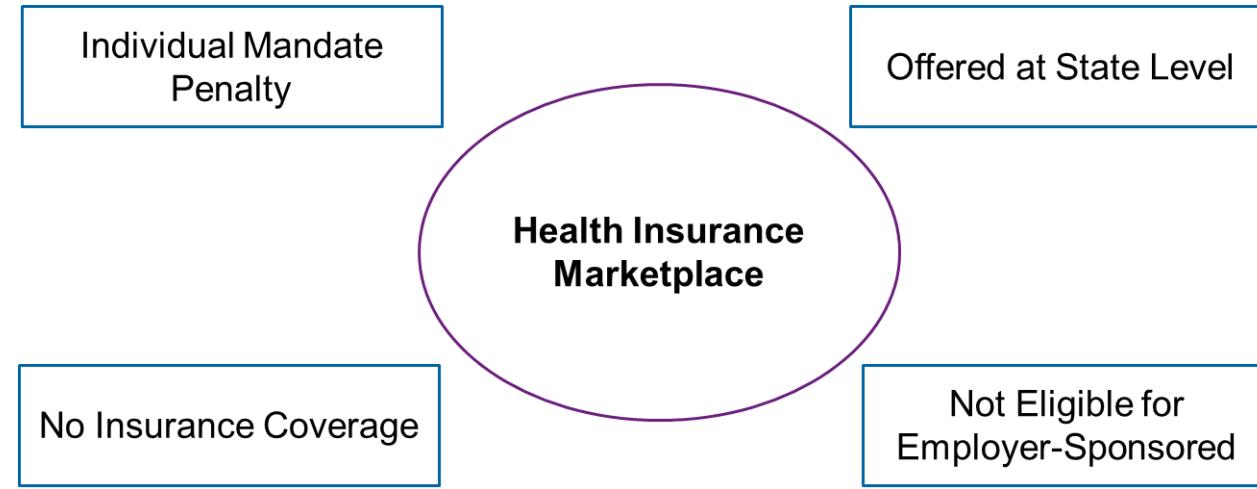
Affordable Care Act



Affordable Care Act



Affordable Care Act



Affordable Care Act

Benefit Standards

Required to cover essential benefits

Tiered Plan Structure

- Platinum – Higher premium, lower OOP
- Gold
- Silver
- Bronze – Lower premium, greater OOP
- Catastrophic

Affordable Care Act

Elimination of Pre-Existing Exclusions

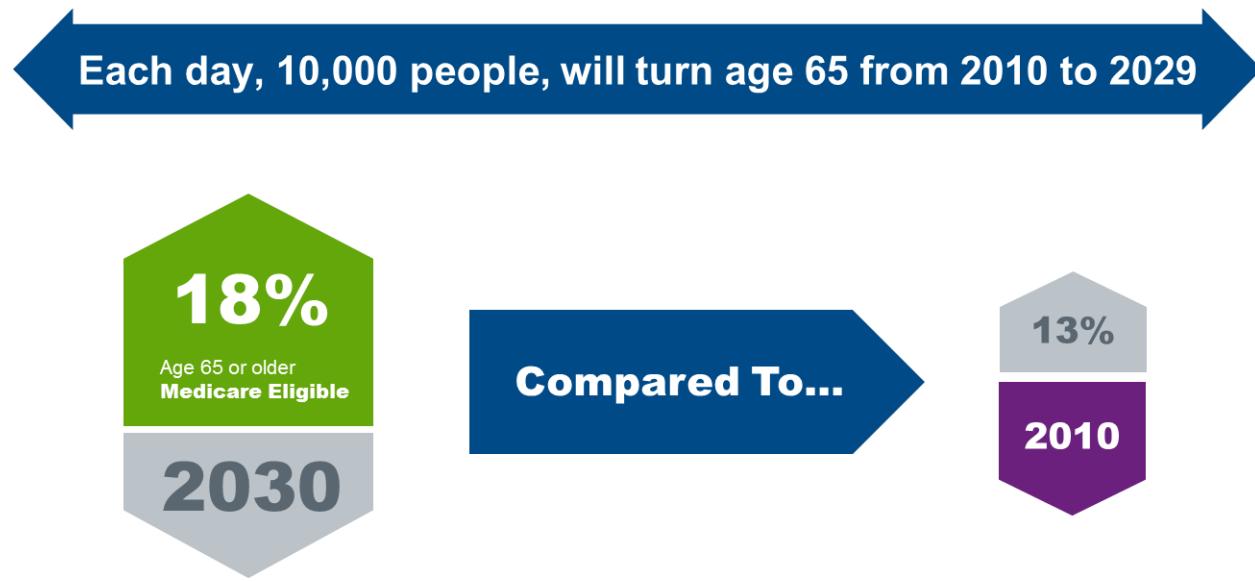
- Prohibits denial or non-renewal of coverage
- Prohibits premium upcharge

Guaranteed Issues and Renewability Requirements

- Renewals even when chronically ill
- Renewals even if high cost claims incurred



Aging Population



HIPAA

Health Insurance
Portability and
Accountability Act

Federal Law

Prohibits disclosure of
confidential information

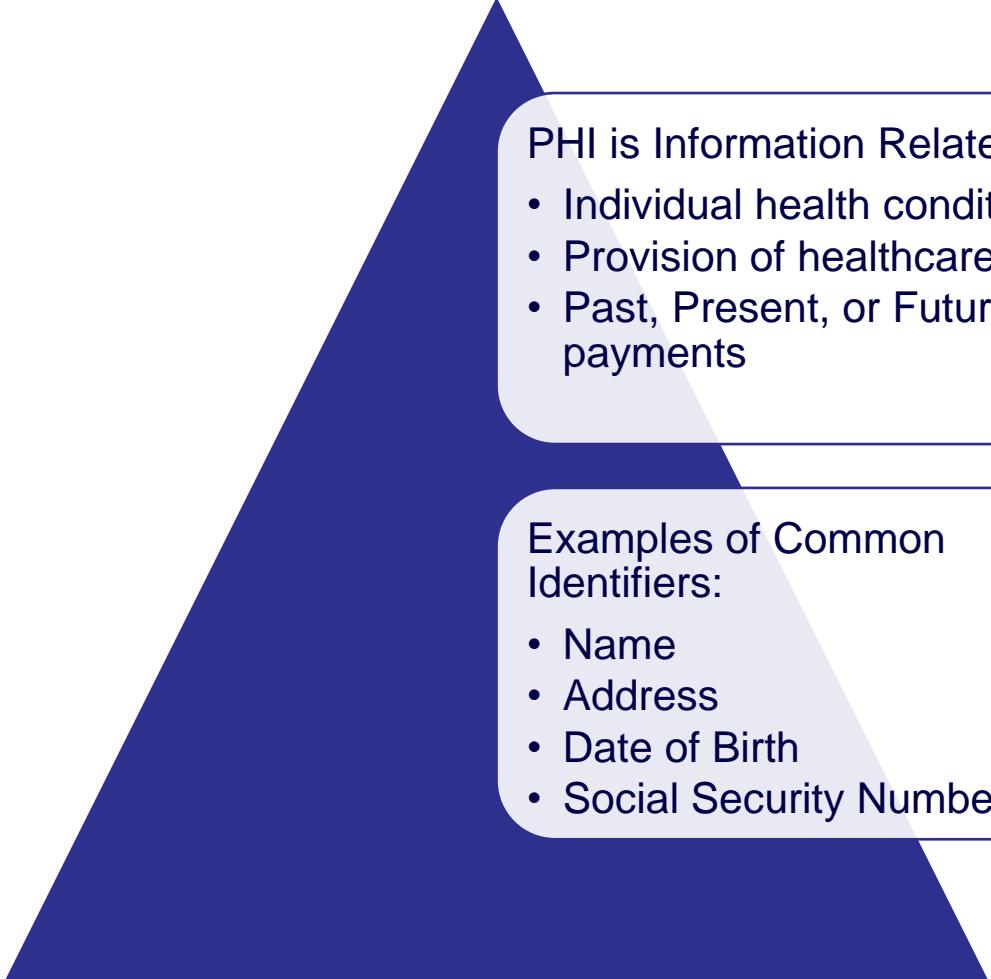
Disclosure allowed with
written authorization

Protected Health Information

- PHI as defined by Department of HHS:

“Individually identifiable health information held or transmitted by a covered entity, or its business associate in any form or medium, whether on paper, electronic, or oral.”

Protected Health Information



PHI is Information Related to:

- Individual health condition
- Provision of healthcare
- Past, Present, or Future payments

Examples of Common Identifiers:

- Name
- Address
- Date of Birth
- Social Security Number



Thank you