Once upon a time in a city, there was a large healthcare company named **"HealthPlus"** that offered various insurance plans to its members. The company was looking for a way to manage its complex claims processing, provider relationships, and ensure its customers got the best healthcare benefits without getting tangled in too many rules. That’s when **Facets**, a software solution by **Cognizant's TriZetto**, came to their rescue.

**Scene 1: Setting Up Health Plans**

The company wanted to offer a variety of plans for different needs, like **Medical, Dental, and Vision**.  
HealthPlus categorized these options into **(Types of Policies)**:

1. **(Individual Policy)**: John, being a young bachelor, chose an individual policy where he himself would pay the premium directly.
2. **(Group Policy)**: His colleague Emma, on the other hand, was enrolled under a **(Group Policy)** where their company, as a **(Sponsor)**, paid the premium on behalf of her and other employees.
3. **(Government Policy)**: John’s friend, Mr. David, an elderly retired man, was under a **(Government Policy)** where the government took care of his premium payments.

Policy -> Like **Individual Policy** , **Group Policy** , **Government Policy**.

Each of these Policy has many

Plans -> like **Gold Plan** (OOPs less), **Silver Plan** (OOPs medium), and **Bronze Plan** (OOPs High).  
Products -> like **Medical, Dental, and Vision** (specific benefits)  
  
**Policy** → Contains multiple **Plans**.  
Each **Plan** → Contains multiple **Policy.**  
Each **Plan** → Contains multiple **Products**.  
Each **Product** → Contains multiple **Plans**.

**Policy -> Plans -> Products**

1 Policy -> N Plans || 1 Plan -> N Policies  
1 Plan -> N Products || 1 Product -> N Plans   
1 Product -> N Benefits || 1 Benefit -> N Products   
  
Every plan needed to have detailed information like:

* Who can enrol in the plan (Eligibility)?
* What are the benefits? For example, **Routine Check-ups**, **Surgeries**, and **Emergency Visits**.
* How long the coverage will last for each person (Stop Age).
* When does the coverage start after someone enrols (Waiting Period)?
* What are the Types of Transactions available under the plan? For instance:

Cashless Transaction: When the Provider raises an authorization request to the Payer. Once approved, all the covered expenses will be paid by the Insurance Company (IC). If there are any non-covered expenses, the member has to take care of them.

Cash Transaction: When the Member pays for the treatment upfront and later submits  
a Claim for reimbursement.

To organize all of this information, the team used **Facets**. They started by creating **Plans** and linking them to **Products**.

* **Plan**: A high-level category like "HealthPlus Gold Plan."
* **Product**: The detailed structure that includes all the benefits, rules, and pricing .

For instance, if a new member, **John**, joins the **HealthPlus Gold Plan** in January 2023, his coverage begins immediately because there’s no waiting period for new employees (Waiting Period = 0).

HealthPlus Gold Plan falls under the category of **(Health Insurance)**, where members pay a **(Premium)** on a **(Frequency)** basis, either Monthly, Yearly, or Semi-Annually.

The relationship between John and HealthPlus is defined through a **(Policy)**, a contract between the patient and the **(Insurance Company)**, which is represented by HealthPlus here.

John’s colleague, Emma, also had her family members covered. In her case, she was the **(Subscriber)**, and her spouse and children were her **(Dependents)**. Together, they formed a **(Member)** unit under her policy.

**Scene 2: John Visits a Doctor**

One day, John wasn't feeling well and decided to see a doctor. The doctor he chose was a part of the **HealthPlus Network** (Participating Provider), which meant he could go for treatment without paying extra charges. This relationship between **HealthPlus** and the doctor was pre-determined by a **Network Set** (Collection of Providers).

* If John visited a doctor outside this network, he would have to pay higher fees because that doctor would be considered **Out of Network**.

John’s visit to the doctor was logged in Facets using a special code called a **Procedure Code** (99215). This code was part of the **Standard Industry Codes** list that Facets maintained to ensure that services provided are billed correctly. Along with that, a **Diagnosis Code** was added to show what condition John was being treated for.

John received his treatment at a **Provider** location, which could be a **Physician's office, hospital, or a lab facility**. In this case, the **Provider** played a key role in delivering the healthcare service to John, and the **Provider** entity's details were stored in the **Facets** system.

**Provider Types:**

* **Participating Provider**: **In-network** provider who has an agreement with the insurance company (HealthPlus in our case). Members pay lower costs for services from these providers.
* **Non-Participating Provider**: **Out-of-network** provider who does not have an agreement with the insurance company. Members typically pay higher costs for services from these providers.

But John also had 3 choices in terms of **Provider Types (in both Participating and Non-Participating categories)**:

* Practitioner/ Facility -> Single healthcare provider   
   -> Family doctor **or** Specialist, **or** Dentist + **a** Hospital power
* Provider Group -> Collection of multiple Practitioner  
   -> Family doctor **+** Specialist, **+** Dentist + **a** Hospital power

IPA (Independent Practice Association)  
 -> Collection of multiple Provider Group  
 -> Family doctor **+** Specialist, **+** Dentist + **Many** Hospital power

If John had gone to a **Non-Participating Provider** (someone outside the network), the charges would have been higher, and John might have had to pay a larger part of the cost himself. But since John visited a **Participating Provider**, he enjoyed lower costs, thanks to the agreement between the provider and HealthPlus.

The **Provider Creation** process in Facets is a two-step process:

1. **Common Practitioner Information**: This includes static information like the provider's **name**, **date of birth**, **gender**, and **qualification**.
2. **Practitioner Details**:

**Multiple Specialties**: If the doctor practices in different fields, such as both **General   
 Medicine** and **Cardiology**, this information is stored here.

**Multiple Practice Addresses**: The doctor could have different clinics or hospitals   
 where they practice.

**Multiple Tax IDs**: A provider may have different tax IDs  
 for different clinics or business entities.

**IPA/Provider Group** Affiliation: If the doctor belongs to an **Independent Practice  
 Association (IPA)** or a **Provider Group**, those details are also captured.

John’s treatment type was recorded as an **Inpatient** or **Outpatient** service, depending on the duration and nature of the treatment:

* **Inpatient (Inpatient Claims)**: If John was admitted to the hospital for more than 24 hours, his treatment would be classified as **Inpatient**.
* **Outpatient (Outpatient Claims)**: If John’s treatment was completed within the same day or less than 24 hours and he returned home, it would be classified as **Outpatient**.

The pricing for John’s treatment was derived based on the **Agreement** between HealthPlus and the **Participating Providers**. This agreement outlines what services are covered, the **Place of Service (POS)**, and the **cost for each service**.

**Network Structure**:

* HealthPlus operates through a **Network**, which is essentially a collection of providers.
* These providers are grouped into **Network Sets (CTS IND , CTS USA, CTS AUS)**, which are supersets of all networks HealthPlus manages.
* Each **Network Set** is mapped to the class/plan definitions, ensuring that the same benefits apply to all providers in that set.

**Scene 3: Processing the Claim**

After the visit, the doctor generated a **Claim** for the services provided to John. The claim went through **Claims Adjudication** (the process of evaluating whether the claim is eligible for payment and how much should be paid). Facets uses several components to make this **decision** or **Adjudication**:

1. **Place of Service (POS)**: Defines where the service was provided, e.g., at a hospital or in a clinic.
2. **Explanation Codes**: Justifications added to clarify why a claim was approved, denied, or partially paid.
3. **Benefit Components**: Rules like whether the service was eligible under John’s plan, or if a deductible needs to be paid first.
4. **Eligibility (w.r.t. claims)**: Ensures that:

* The **Member** is **active** in the plan.
* The **Member** has **paid the premium**.
* The **treatment** was actually **given or not**.
* The **treatment** is **covered in the policy**.
* The **Sum Insured (SI)** limit has been met or not.
* The **claim** is not a **Duplicate Claim**.

Example: For John’s policy (Plan P1), his **Sum Insured (SI)** limit was set at **3 lakhs** (3L).

The **Sum Insured (SI)** limit is typically set by the **Insurance Company (IC)** based on the policy or plan selected by the member.

Below is how it worked for different claims he made:

* On 2nd of the month, he made a claim **(C1)** for **1L** -> Insurance Company (IC) **Pays**.
* On 4th of the month, he made a second claim **(C2)** for **2L** -> IC **Pays**.
* On 9th of the month, he made a third claim **(C3)** for **50K** -> **IC will not pay**, as the  
   total claim amount has exceeded the SI limit.

Facets verified John’s claim by checking these rules, ensuring that it was processed accurately and met all eligibility requirements before deciding on the amount to be paid.

**Application Support Application Group** comes into play here, which acts as a central library providing standard industry codes (e.g., **Procedure Code**, **Diagnosis Code**, **Revenue Code**, and **Service Code**) as well as user-defined codes. These codes ensure that the healthcare services John received are accurately tracked and billed. Facets uses this information to process John’s claims properly.

**EXAMPLE :-**

Procedure Code  
------------------------

eg: Procedure Code = 99215

Effective Date = 01/01/2023

In **Claims Processing**, we **cannot** use this procedure Code for any claims **submitted before**  
 01/01/2023

**On or after** the effective date, the procedure code can be used **for claims processing**.

**Effective Date** = **Blank** in the front end (01/01/1753)

I can **use this procedure code** for any dated claim, when **eff** and **term** date is **blank**.

Action

NA - Not applicable

E - Error, any claim line item with this procedure code will be ending in Error.

W - Warning, any claim line item with this procedure code will be generating a warning  
 message

D - Deny, Any claim line item with this procedure code will be denied. (Claim process is  
 successful but the benefit amount is 0) **Explanation code** **is mandatory**

Procedure code is 5 byte

Modifier ==> used to add variation to the procedure code --> 2 byte (alphanumeric)

claims processed with only Procedure code then Proc code will be 5 digits

Claims Processed with Procedure Code + Modifier then Proc Code will be 7 digits

SELECT \* FROM **CMC\_IPCD\_PROC\_CD**

Diagnosis Code  
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eg: Diagnosis Code = 417

Effective Date = 01/01/2023

In Claims Processing, we cannot use this Diagnosis Code for any claims submitted before 01/01/2023

On or after the effective date, the Diagnosis code can be used for claims processing.

Effective Date = Blank in the front end (01/01/1753)

I can use this Diagnosis code for any dated claim, when eff and term date is blank.

Action

NA - Not applicable

E - Error, any claim line item with this Diagnosis code will be ending in Error.

W - Warning, any claim line item with this Diagnosis code will be generating a warning message

D - Deny, Any claim line item with this Diagnosis code will be denied. (Claim process is successful but the benefit amount is 0) Explanation code is mandatory

SELECT \* FROM CMC\_IDCD\_DIAG\_CD

Revenue Code

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SELECT \* FROM CMC\_RCRC\_RC\_DESC

EXPLANATION CODES

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System Reserved Explanation COdes will be used for all in built logic which comes along with the Product.

This **Application Support Application Group** acts as the backbone of Facets, ensuring that all claims are processed uniformly and based on industry standards. This way, HealthPlus can maintain accuracy and consistency in claims adjudication, which is crucial when dealing with hundreds or thousands of claims daily.

After the visit, the doctor generated a **Claim** for the services provided to John. This claim underwent **Adjudication** (the process of determining whether the claim could be paid and how much should be paid). Several systems and calculations came into play to ensure the correct processing:

1. **Adjudication Process**:
   * **TPS (Trizetto Provider System)**: A portal where the Provider submits bills and receives decisions from the Insurance Company (IC).
   * **Facets Core Pricing** and **NetworX Pricer**: These tools help calculate the pricing for services.
   * Evaluates whether the claim can be paid and determines the **Max Allowed Amount**.
2. **CCA (Clinical Care Advance)**: Ensures proper clinical guidelines are followed before claim approval.
3. **Final Benefit Amount Calculation**:  
   The **Benefit Amount** that John’s doctor receives is calculated as:  
   **Benefit Amount = Max Allowed Amount - OOP - COB (if any).**
4. **Claim Status Handling**:

**Adjudication** **Process**: After being processed by TPS and Facets Core Pricing, John's claim goes through multiple stages. The claim status changes as it starts as

**Check** -> **Accept**, **In Between** -> **(** **Pended**  or **Paid** or **Adjust )**  **, Finally -> Close**.

The various stages are as follows:

01 – **Accepted**: John’s claim is first accepted after passing all the initial checks. The system confirms that the details like the service code and diagnosis code are correct, and the claim is valid.

11/15 – **Pended**: Sometimes, claims may have missing or incorrect information. If John’s claim had incomplete details or errors, it would be moved to the "Pended" status. This means the claim is on hold, waiting for someone in the claims department to fix the issue.

02 – **Paid**/Finalized: Once all the issues are resolved and the claim is processed, it moves to the Paid/Finalized status. This means John’s doctor has been paid for the services rendered.

91 – **Adjusted**: If there’s a mistake, like an overpayment or underpayment, John’s claim may enter the Adjusted status. This only happens if the claim was already finalized and paid. The claim will be corrected and re-evaluated for the right amount.

99 – **Closed**: Finally, once the claim is completely settled, whether it was paid, denied, or adjusted, it enters the Closed status. No further actions can be taken on John’s claim, as it is now fully processed and resolved.

* + If the claim encounters an issue:  
    **C1 → Error → Pended with Errors (on hold)**
  + If **no error** is found:
    - **Benefit Amount = 0**: Claim Denied/Rejected (Medical Expenses not covered).
    - **Benefit Amount > 0**: Claim approved, and the eligible amount will be paid.

When John goes to the clinic, the doctor’s visit and services must be **documented and billed** using different **codes**.

1st. **Service Code - VO**:

* This is a general **code for the type of service**, in this case, **fever treatment**. It categorizes what kind of care John came in to get.

2nd. **Procedure Codes**:

* These **codes describe specific actions** performed by the doctor:
  + **Appointment** → **99215**: This code shows that John had a consultation with the doctor.
  + **Temperature Check** → **99216**: This code records the service of checking John’s temperature.
  + **BP Check** → Recorded but doesn’t need a special code here unless it’s part of the treatment plan.

**3rd. Diagnosis Code**:

* The **doctor asks questions** like:
  + “How long have you had the fever?”
  + “Do you have any cold or cough?”
  + “Have you eaten food outside?”
* These questions help the doctor figure out **why John has a fever** (root cause). The **Diagnosis Code** will reflect the reason (like **viral fever** or **food poisoning**).

**4th. Revenue Code:**

* Used for **billing specific services** like **hospital stays (room and board)**. If John was admitted, this code would apply.

**Why These Codes Matter:**

Procedure Code, Diagnosis Code, and Revenue Code are **standardized** by

**CMS (Centres for Medicare & Medicaid Services)** so that:

* Every healthcare provider and insurance company use the **same codes**.
* It ensures **accuracy and consistency** in **claims processing**.
* The insurance company knows **exactly what service was provided**, how to pay for it, and if it’s covered by John’s policy.

These Procedure Code, Diagnosis Code, and Revenue Code are called as Industry Standard Codes.

**Where IT goes:  
CODEs:-**

1st. This information is **uploaded into the Facets system** (used by insurance companies like HealthPlus).

2nd. The claim moves through **TPS (Trizetto Provider System)** **used by healthcare providers** (like doctors, hospitals, etc.) to submit claims to insurance companies for payment and for further processing.  
  
3rd. **Facets system** matches the codes to the **member’s policy** and **benefits**.

Example:

* **Procedure Code** ensures the service (e.g., consultation) was covered.
* **Diagnosis Code** checks if the condition (fever) is eligible for coverage.

4th. **Facets Core Pricing** and **NetworX Pricer**: -> **How much the IC will pay** for each service.

5th. **Max Allowed Amount is then calculated .**

6th. **CCA (Clinical Care Advance):** Ensures clinical guidelines are followed correctly.

7th. **Benefit Amount Calculation** = Max Allowed Amount – OOP – COB (if applicable).

**Payment to the Provider:**

**Provider Payment:**

* + **Where it goes**:
    - Once the insurance company processes the claim, the payment is **transferred to the doctor’s account**.
    - If the **provider** is on a **Fee-for-Service (FFS)** contract, he will receive payment **for each service listed** in the Procedure Code (99215, 99216).
    - If on **Capitation**, the **provider receives a fixed monthly amount** per enrolled member, regardless of the number of visits.

**Explanation of Benefits (EOB) Sent to John:**

**EOB (Explanation of Benefits):**

* + **Where it goes**:
    - The **EOB document is sent to John** by the insurance company, showing:
      * **What services were covered**.
      * **How much the insurance paid**.
      * **Any remaining amount John needs to pay** (if applicable).

**Scene 4: Provider Payment**

After John’s claim was processed, **HealthPlus** had to pay the doctor **(Provider)**. This payment depends on how the doctor **(Provider)** is contracted (i.e Provider Payment Method) with **HealthPlus** .

There are TWO Models :-

* **Fee for Service (FFS)**: If John’s doctor is part of a **FFS contract** i.e charges per service, he gets paid for each visit or procedure done. This model often leads to unnecessary treatments and higher healthcare costs (HC cost), which can result in a **loss for the Insurance Company (IC)**.
* **Capitation**: If the doctor is part of a **Capitation contract**, he gets a fixed amount per member per month (PMPM), no matter how many times members visit him. Basically it is a type of **Risk-Sharing Arrangement model.** This encourages providers to focus on preventive care and avoid unnecessary treatments, helping manage costs effectively.

For example, if John’s doctor had a **Capitation Contract** of $2000 for 10 members, he would receive $20,000 monthly even if John and others didn’t visit him that month.

**Capitation in Action**

Prov1 (John's provider) has a Capitation Contract of $2000 PMPM.

* January: 10 enrolled members → $2000 × 10 = $20,000
* February: 5 enrolled members → $2000 × 5 = $10,000
* March: 15 enrolled members → $2000 × 15 = $30,000

In January:

* **M1 (Healthy Member)**: Does not visit the provider.
  + **IC pays** $2000 to the provider.
  + **Result**: IC incurs **$2000 loss**, provider gains **$2000 profit**.
* **M2 (Unhealthy Member)**: Visits the provider for a treatment costing $5000.
  + **IC pays** $2000 to the provider.
  + **Result**: IC earns **$3000 profit**, provider incurs **$3000 loss**.

This model prevents unnecessary treatments while encouraging **preventive care** and **wellness programs**, such as:

* **Education**
* **Health Camps**
* **Vaccination**
* **Diet Consultation**
* **Counselling Sessions**

This strategy ensures that providers focus on maintaining members' well-being, reducing long-term healthcare costs.

**Scene 5: Administrative Configurations**

Meanwhile, the **HealthPlus** admin team ensured that rules like **Stop Age** and **Waiting Period** were in place:

* **Stop Age**: If John turned 65, his coverage would automatically end, as 65 was the designated stop age.
* **Waiting Period**: If John joined the company on January 1st, 2023, and his plan had a 10-day waiting period, his coverage would start on January 11th, 2023.

**HealthPlus** also used a **(Rate Guarantee)** to keep premiums unchanged for the next two years, giving John peace of mind that his costs wouldn’t increase suddenly.

Additionally, the team needed to consider **Pre-existing Conditions** when setting up the policies:

* If a member like John’s colleague, **Mark**, joined the **HealthPlus Gold Plan** on January 1, 2022, without any prior health issues, any new condition developed after this date would be covered.
* However, if another member, **Sam**, who was already being treated for a heart condition since January 1, 2021, joined the plan on January 1, 2022, any expenses related to his heart condition wouldn’t be covered, as it would be considered a **Pre-existing Condition**.

To further manage the providers and treatment options, HealthPlus categorized providers using **Networks**:

* **Network**: A collection of doctors and hospitals.
* **Network Group**: A group of multiple networks.
* **Network Set**: A superset containing all the network groups.

For example, **CTS India** represents the Network Set with multiple groups within it:

* **CTS India**:
  + **NWGNW** (Network Group):
    - **Pun**
    - **Kol**
    - **Noi**
  + **SWGNW** (Network Group):
    - **CHN** (Network):
      * Apollo Hospital
      * Kauvery Hospital
    - **HYD** (Network)
    - **BLR** (Network)

This classification ensured members knew which doctors and hospitals were covered under their plan. For example, if John visited a doctor outside the **Network Set**, his claim might not be fully covered. This allowed HealthPlus to maintain clarity and control over which providers were **In-Network** or **Out-of-Network** for different plans and policies.

* **In-Network**: Providers that have a tie-up or contract with HealthPlus.
* **Out-of-Network**: Providers that do not have a contract with HealthPlus.

The **PCP (Primary Care Physician)** acted as a **Gatekeeper** to ensure members were directed to the right specialists within the network, helping to manage costs and care quality effectively.

**Scene 6: Complex Claims and Coordination of Benefits (COB)**

One day, John got injured and had to get treatment either **In-network** or **Out-of-network**. If Jhon has multiple insurance policies then **Coordination of Benefits (COB)** comes in to picture.

If John had another insurance policy, HealthPlus would decide whether to be the primary or secondary payer.

* **Primary Payer**: Pays first and covers the maximum allowed amount.
* **Secondary Payer**: Covers the remaining amount after the primary payer has made its contribution.

**Cost Shifting and Maximum Allowed Amount**

**Cost Shifting** ensures that any losses from one member’s claim can be balanced by the profit from another. HealthPlus also sets a Maximum Allowed Amount—the highest amount the insurance will pay for a specific service, ensuring effective payment management.

**Real-Life COB Example with Multiple Policies**

Let’s say John’s parents have two policies:

* **Mom’s Policy**: Coverage limit of **$6000**
* **Dad’s Policy**: Coverage limit of **$4000**

**Scenario 1: Treatment Costs $8000**

1. **Mom’s Policy** (Primary Payer) pays: **$6000**
2. **Dad’s Policy** (Secondary Payer) covers the remaining:
   * **$8000 - $6000 = $2000**
   * Dad’s policy covers the smaller amount: **$2000**

Total Coverage = **$8000**

**Scenario 2: Treatment Costs $12,000**

1. **Mom’s Policy** (Primary Payer) pays: **$6000**
2. **Dad’s Policy** (Secondary Payer) covers up to its limit:
   * **$12,000 - $6000 = $6000**
   * Dad’s policy pays **$4000**, its maximum coverage.

Total Coverage = **$10,000**  
The member will need to pay the remaining **$2000** out of pocket.

**Scene 7: Making Adjustments and Benefits Enhancement**

**HealthPlus** wanted to add new benefits like **Vaccination Camps** and **Counseling Sessions** under John’s plan. Using the **Benefit Components Table**, they updated the plan to include these new benefits and set new **Variable Components** for cost-sharing like copays or deductibles.

If John wanted to use these services, he could now do so without incurring extra charges. All these changes were stored in the **Administrative Information Table**, ensuring the system was always updated.  
  
  
In Making Adjustment section there is a term OOP expense Game comes in.  
COB (Coordination of Benefits) works across multiple policies

CSM (Cost-Sharing Mechanism) is within one policy like OOP

Policy -> Policy partially -> Policy fully active

-> Policy Deductible -> OOP (Max)  
  
Starts -> Deductible -> OOPs calculation will start -> COB  
  
**COB + OOP Example:**

1. **Mom’s Policy (Primary):**
   * **OOP Max = ₹3,000**
   * Deductible + Coinsurance + Copay already paid = ₹3,000
   * Policy is now **fully active**—no additional OOP expenses.
2. **Dad’s Policy (Secondary):**
   * **OOP Max = ₹2,000** (but not relevant unless secondary kicks in)

**Scenario: John Gets Hospitalized (Cost = ₹1,00,000):**

* **Primary Policy (Mom’s)**:  
  Since **OOP max** is reached, **John’s entire hospitalization** will be **covered by mom’s policy**. No need for the secondary policy to step in.
* **If a Treatment Exceeds Mom’s Policy Limits** (e.g., ₹1,20,000 limit for hospitalization):
  + **Mom’s policy** pays ₹1,20,000 (full limit).
  + **Dad’s policy** (secondary) can cover any remaining amount beyond that limit.

**cost-sharing mechanisms** OOP:

* **Copay:** John had to pay a small fixed amount (e.g., $30) for his next doctor consultation.
* **Coinsurance:** After meeting the deductible, John was responsible for 10% of future treatment costs, with the **insurance covering 90%**.
* **Deductible:** Before insurance began covering treatments, John needed to meet a **deductible amount**, say $500, from his own pocket.

**OOP Max**: $3000 reached -> benefit period start (reset per calendar year).

**OOP Lifetime Limit**: $999,999,999, -> Life time free service ON

**Copay, Coinsurance, Deductible, OOP Max**, and **OOP Lifetime Limit** are tracked with **Accumulators**.  
  
Accumulator = Summing up of all OOP expenses  
All Policy Pay = Sum Insured   
  
flow :-  
  
1st Total Expense = ?

2nd Deductible = ?  
  
3rd Coinsurance = ?  
  
4th Copay = ?  
  
5th OOP = ? ->  
  
6th If OOP = OOP max   
NO -> Member pay = OOP   
YES -> Member pay = OOP – OOP max  
  
7th Policy pay (IC) = Total expenses – Member pay   
  
8th Accumulator = Summing up of all OOP expenses  
  
  
  
  
**Pharmacy and Provider Flexibility**

For medications, HealthPlus partnered with a **PBM (Pharmacy Benefit Manager)** to keep prescription costs manageable. PBMs ensured that essential drugs were accessible at the lowest prices through effective formulary management.

Referrals -> PCP (Primary Care Physician)

John also had various plan options based on his preference:

* **HMO (Health Maintenance Organization):** Lowest cost, **In-Network** only, Yes Referrals required.
* **PPO (Preferred Provider Organization):** High Cost, **In-Network** + **Out-Network**, No Referrals req.
* **EPO (Exclusive Provider Organization):** Moderate cost, **In-Network** only, No Referrals required.
* **POS (Point-of-Service):** Moderate cost, **In-Network** + **Out-Network**, Yes Referrals required
* **Medicare :** (**federal** or **central government**)
  + **Elderly** 65 or older **>=65.**
  + **Younger** individuals with disabilities
  + **Any people** who has End-Stage Renal Disease (ESRD) or Amyotrophic Lateral Sclerosis (ALS).

Medicare offers four parts:

* **Part A**: Covers **hospital benefits**. This is a **traditional indemnity plan**, where **providers are paid through FFS (Fee-for-Service)**. Members don’t pay premiums, but **deductibles and coinsurance** apply.
* **Part B**: Covers **outpatient services** such as **doctor visits and therapy**. Members pay **premiums based on income** and need to meet **deductible and coinsurance requirements**.
* **Part C (Medicare Advantage Plan)**: Combines **Part A** and **Part B** with extra services. Members deal with **OOP (Out-of-Pocket) expenses**. Providers are paid per **contract**, ensuring cost control.
* **Part D**: Covers **prescription drug costs** **and late enrolment penalties with premiums**.

To handle situations where members might not have complete coverage, HealthPlus added **Medigap policies** to fill the **coverage gaps**, reducing their out-of-pocket burden. These policies are regulated by **federal** or **central government** and come with smaller premiums.

John, unfortunately, discovered a **coverage gap** when he tried to access certain medical services. A **coverage gap** occurs when a member's insurance policy doesn't cover specific expenses or when their coverage temporarily lapses.

To ensure John was protected against unexpected costs, **HealthPlus** offered an additional option:

**Medigap Policies**: These are **Medicare Supplement Insurance** plans that   
 fill the gaps left by Medicare.

* + They **cover out-of-pocket expenses** like copays, coinsurance, and deductibles.
  + **Federal and State laws regulate** these policies, ensuring members receive the necessary benefits.
  + John needed to **pay a premium** for this supplemental coverage, but it was relatively affordable compared to the potential costs he could face without it.

With Medigap in place, John felt more secure knowing that even if his standard Medicare policy had limitations, the **supplemental insurance** would cover his **remaining costs**.

* **Medicaid :** (**Central government**) and (**State** **government**)
  + **Elderly** with disabilities
  + **Children**
  + **Pregnant women**
  + **Any people** Low-income below the federal or central poverty line

example -> HealthPlus Comprehensive Insurance Policy (**Policy**)  
 -> HealthPlus Gold Plan  
 -> HealthPlus Silver Plan  
 -> HMO , PPO, EPO, POS

**Automation and Information Exchange**

To keep the claims process efficient, HealthPlus used:

* **EDI (Electronic Data Interchange):** For seamless exchange of billing and claim-related data between providers and HealthPlus.
* **EOB (Explanation of Benefits):** Detailed summaries were sent to John after each claim, explaining what was covered and what wasn’t, ensuring transparency.

**Credentialing and Background Verification**

HealthPlus ensured that all doctors and healthcare providers in their network went through **Credentialing**—a thorough **background verification process** to maintain quality standards.

**Seamless Information Exchange and Credentialing**

HealthPlus used **EDI (Electronic Data Interchange)** to exchange billing and claims data efficiently with providers. After every claim, John received an **EOB (Explanation of Benefits)** detailing what was covered and what wasn’t.

To maintain service quality, HealthPlus required that all providers go through **Credentialing**—a thorough **background verification process** ensuring all doctors, hospitals, and other providers met HealthPlus' high standards.

One day, John got injured and had to get treatment in a hospital (In Network or Out Network).

HealthPlus was able to determine how much to pay by checking **Coordination of Benefits (COB)**. If John had another insurance policy, HealthPlus would decide whether to be the primary or secondary payer.

* **Primary Payer**: Pays first and covers the maximum allowed amount.
* **Secondary Payer**: Covers the remaining amount after the primary payer has made its contribution.

This COB concept is also vital for **Dual Eligible members** – people like John’s elderly uncle, who qualifies for **both Medicare and Medicaid**. These are often called **Medi Medi cases**.

* **Medicare** serves as the **first payer**, covering most of the healthcare costs.
* **Medicaid** acts as **secondary coverage**, helping with expenses that Medicare doesn’t fully cover, like copays and deductibles.

Additionally, **Medigap Policies** come into play for those who have only Medicare and need to fill gaps in their coverage. Medigap helps with **Out-of-Pocket (OOP) expenses**, ensuring financial peace of mind. However, **Medigap isn't needed for dual-eligible members** since Medicaid already handles secondary costs.

**Enrolment and Eligibility Management**

HealthPlus also ensured that **enrolment periods** and **eligibility windows** were clear, allowing members to join policies at the appropriate time.

* **Enrolment Periods**:
  + **Initial Enrolment Period**:   
      
    **When**: The first time someone becomes eligible for a policy (e.g., turning 65 for Medicare).

**Example**: John turns 65 in June. His IEP starts 3 months before (March), includes his birthday month (June), and ends 3 months after (September).

👉 If he enrols early, his coverage starts from June 1st. If he delays, the coverage may begin later.

* + **Special Enrolment Period**:  
      
    **When**: For people with special circumstances, like losing employer-based coverage or moving to a new area.

**Example**: John changes jobs and loses his health insurance. He gets a 60-day **SEP** to  
enrol in a new policy without penalties.

* + **General Enrolment Period**:   
      
    **When**: Held annually if someone missed enrolling during IEP or SEP.

**Example**: If John didn’t enrol in Medicare during his IEP, he can do so between January  
and March.

👉 Coverage starts on July 1st, but he may pay penalties for late enrolment.

* + **Open Enrolment Period**:

**When**: A yearly window where anyone can change or join new plans without restrictions.

**Example**: John has an existing plan but decides he wants a different one. During OEP  
(usually in the fall), he can switch to a better plan starting in January of the next year.

**Scene 8: Utilization and Management (UM) Programs & Facets Platform**

As HealthPlus grew, To ensure that members, including John, received appropriate care without incurring unnecessary costs , HealthPlus started a program -> **Utilization and Management (UM) Program**.

This Program ensured that every medical service John receives is necessary and cost-effective, whether it’s a consultation with his **Primary Care Physician (PCP)** or a referral to a specialist.  
  
i.e Medical service John receives is necessary (YES) -> UM notes it   
i.e Cost-effective (YES) -> UM calculates it   
i.e Correct consultation with his **Primary Care Physician (PCP)** (YES) -> UM verifies it  
i.e Referral to a specialist (YES) -> UM checks it

This all (YES) in total is called as **Authorization** , given by **Utilization and Management (UM)** program before John could get treated by any specialist.

This level of control and coordination in healthcare services is powered by the **Facets Platform**, which HealthPlus uses to manage various components of the healthcare system. Facets leverages specific naming conventions and architecture to keep track of everything, ensuring that no detail is missed.

**Facets Naming Convention** also comes into play here to manage these records systematically:

* **CMC\_GRGR\_GROUP**: The **group** structure used in Facets.
* **CER**: **Refers** to the system handling core elements.
* **CMC**: **Managed Care**/Transactional, used for transactional data processing.
* **CDS**: **Reporting** system, used for generating various reports based on member and provider activity.
* **CCS**: **Customer Service system**, handling member inquiries and support requests.
* **NWX**: The system that manages the **NetworX** component, handling network provider details.
* **FHG**: The **HIPAA Gateway**, managing compliance with HIPAA regulations.
* **Custom DB Objects**: In some cases, clients (such as HealthPlus) may need custom database objects to manage unique data. These objects start with the client name as the 1st qualifier, followed by a 4-byte **mnemonic** representing the stored information. Example:
  + **EMBT\_** and **TMGSP\_** for custom data.

Additionally, the **\_CK (Contrive Key)** is used to uniquely identify various records, ensuring there is no overlap or confusion in the system.

**Scene 9: Powering Everything with Facets – Configuring Products and Benefits**

**POWER Of Facets :-**

Enterprise wide Integrated Platform -> **Facets** as a super app that connects everything in a healthcare company like HealthPlus. It manages claims, policies, providers, and payments in **one place**.

Modular Functionality -> Imagine a **LEGO set** where each piece (or module) has a **specific  
 function**—like one module handles claims, another manages  
 providers, and a third deals with payments.

Scalability -> Facets can **grow** with the company. Facets can handle more plans, members,  
 and providers as the company grows.

Flexibility -> Facets can **adapt** to the unique needs of any organization.   
 For example, some companies might want to offer special benefits or   
 customized plans,

Broad and Deep Functionality -> Facets offers a **wide range of features**. It’s not just limited to claims management but also deals with authorizations, referrals, coordination of benefits, and even capitation models. And these functions will go in Modular Functionality

Flexible and Open Architecture -> Facets can **integrate easily** with other systems and tools, making it easier for HealthPlus to customize their operations.

Automation and Configurability -> Facets reduces manual work by **automating tasks** like **claims**  
 **adjudication**.

Proven track record -> Facets is trusted by many healthcare organizations and has a history of  
 delivering reliable results.

**POWER Source Of Facets :-**

This smooth operations at HealthPlus is possible because Facets runs on a **robust system architecture.**

**1st Facets Database ->** Stores all the critical information, from member details to claims, provider contracts, and benefit rules.

**2nd Application Servers -> 1** application of Facet can work with multiple application servers N.

**3rd Facets Interactive (Front End Application) ->** HealthPlus employees can access the system using Facets Interactive to check claims, update member information, and manage payments.

**4th Broker Client (Web Portals)** -> HealthPlus also uses **Broker Client web portals** to give external partners, like providers and brokers, **access to certain parts of the system**. This allows doctors to submit claims and brokers to manage member enrolments efficiently, without needing to call HealthPlus each time.

**POWER Flow Of Facets:- (Healthplus)**

**CTS India is the Parent Group (PG)**

**CTS CHN (Chennai branch) is a Group within the Parent Group.**

**CTS CHN SEZ (Chennai -> Sholinganallur branch) is a Subgroup within the Parent Group.**

**In Subgroup level :-**

**CTS CHN SEZ (Chennai -> Sholinganallur Branch) -> Class (Job role, Family status, or Health risks)**

**CTS CHN TBM (Chennai -> Tambaram Branch) -> Class (Job role, Family status, or Health risks)**

**In Class level :-**

**-> Job role ->** High-risk jobs (construction workers) with coverage for workplace injuries. (plans).

**->** Low-risk office workers with standard health. (plans)

**-> Family Status ->** Single employees without dependents.(plans)

**->** Employees with families (spouse & children) are eligible for family coverage. (plans)

**-> Health risks ->** Non-smokers receive lower premiums. (plans)

**->** Smokers pay higher premiums due to increased health risks. (plans)

All Plans to has   
Products (Specific benefits [like **Medical , Dental, and Vision care**], Coverage rules, & Pricing details)

POLICY (Plans + Products), Policy is nothing just a packet of Plans and Its products.

**Power Flow of Facets :-**

Parent Group -> Group (**CTS CHN**) -> Subgroup (**CTS CHN SEZ**) -> Class -> (Plan -> Product) POLICY

(**CTS India**) (**Individual or Organization**) (**High risk |Low risk**)

**NOTE :- Each Product has 100’s benefits**

you need manually map class with the Subgroup  
example :-  
G1  
 CS1 (G1<-CS1)  
 MedPln --> MedProd (it is a drop down option)  
 DntPln --> DntProd1  
 VisPln --> VisProd1

CS2 (G1<-CS2)  
 MedPln2 --> MedProd  
 DntPln --> DntProd2  
 VisPln2 --> VisProd1

G2  
 CS2 (G2CS2)  
 CS3 (G2CS3)

**Configuring Products and Benefits -> Product ko 4 Components mai divide kiya gaya hai**

As the HealthPlus team continued to optimize their system, they realized how important it was to configure each **Product** properly. Every product was like a detailed instruction manual that explained all the **rules**, **regulations**, and **logic for claims processing**.

The **product** acts like a detailed instruction manual for HealthPlus on how to treat different members under different plans.

To understand this, let’s imagine HealthPlus as a restaurant offering meal (plans + Products) policy to John:

* **Plan**: This is like offering different meal options

(e.g., Breakfast Plan, Lunch Plan, Dinner Plan).

* **Product**: **Product** is the **inside** specific meal **Plan**, explaining the ingredients, portions, and preparation methods for each plan

(e.g., Vegan Breakfast or Full English Breakfast).

HealthPlus team divided the Product explanation into 4 components :-

**1ST. Indicative Component** -> Product -> Treatments likha hota hai  
**John submits a request** **for** Claim (or Treatment or **Product**) -> in Facets -> IC -> UM -> Explain   
possible options -> Either John is **going** to have the treatment -> (**Pre-determination**) or (**PrePricing**)  
 -> OR John is **done** with the treatment -> (**Claims Processing**)

Claim   
 -> **Pre-determination** (Thinking) YES|NO   
 -> **PrePricing** (OOPs)   
 -> **Claims Processing** (Checking) YES|NO| Partial  
  
   
 **Pre-determination ->** Pre-determination is like a pre-approval process for any services.   
 John submits a **Pre-determination** request to HealthPlus to see if the   
 treatment will be covered under his plan or not. This helps avoid  
 situations where John gets a service and later finds out it isn’t covered.

**PrePricing ->** Pre-pricing is like John estimated treatment cost say $5,000, HealthPlus might   
 tell John that his Out-of-Pocket (OOP) cost will be $500, and the rest will be   
 covered by the insurance.

**Claims Processing ->** HealthPlus reviews the actual claim after John has received the   
 service. It's about checking whether the service is eligible and   
 determining how much of the cost will be paid by HealthPlus.

**2nd. Business Information Component -> HealthPlus tracks** (**John’s** Plan or **Products**) how much John’s health services cost them and ensures they don’t exceed a certain limit. For instance, John can’t get services beyond $1,000 a month without HealthPlus reviewing it.

**In this component HealthPlus maps different products (like Medical, Dental, and Vision) to LOBs**

**LOB -> Line of Business** , HealthPlus can track their financial performance, see where they are making or losing money.

**i.e. example -> If John enrolls in a HealthPlus medical plan, that plan will map to a primary LOB such as Routine Care (standard scenario), If John goes to an Out of Network (OON) provider without proper pre-authorization (leading to a UM violation).**

**So from example we can see that   
Max 2 LOBs** can be mapped to a **single product** (**Routine Care)**

1st. **Primary LOB** (Standard Scenarios): If HealthPlus has a **product** for routine medical checkups, it will map to a primary LOB such as "Routine Care".

2nd. **Secondary LOB** (**Exceptional/Violation Scenarios**): This LOB comes into play when something out of the ordinary happens, like a UM violation or an Out of Network (OON) scenario.

**Exceptional/Violation Scenarios might include:**

* **UM violation (Utilization Management): This happens when a healthcare service is not in line with the member's plan or policy, for example, services requiring pre-authorization that were performed without it.**
* **OON (Out of Network): When a member goes to a provider outside the contracted network, potentially leading to higher costs.**
* **UM violation (or) OON: Either a UM violation or an Out of Network issue could occur.**
* **UM violation (and) OON: Both a UM violation and Out of Network scenario occur at the same time.**

**3rd. Benefit Component -> John gets** **benefits in each product**

**Benefit Amount = Maximum Allowed Amount - (Deductible + Coinsurance + Copay + Non-Covered Services) - COB (if applicable)**

**Like** Product **Medical Care** -> 3 check-ups per year , **2 emergency visits** annually without needing a referral , John can consult a specialist **twice a year** without an extra copay.

**Like** Product **Dental Care** -> 2 Routine Cleaning per year, **one set of dental X-rays** per year, **50% coverage** for basic fillings.

**Like** Product **Vision Care ->** one comprehensive **eye exam** per year, **$100** allowance toward glasses**, 20% of the cost is covered ,** corrective eye surgery**.**

So , Basically Each product has over 100 benefit components associated with it, and **the mandatory  
components are determined based on the selections made in the Indicative components.**Now**,** I am defining few things   
1st. **Service Code**, **Date of Service (DOS)**, **Member details**, **Provider**, **Procedure Code**, **Diagnosis Code**, **Revenue Code**, and **Total Charge**.  
 -> **Service Code** (what kind of service |treatment |care John came in to get)  
 -> **Date of Service (DOS)** (17-10-2024)  
 -> **Member details** (Jhon , age =22 , family status = unmarried)  
 -> **Provider details** (Doctor | Hospital [Apollo])  
 -> **Procedure Code** (specific actions performed by the doctor)  
 -> **Diagnosis Code** (root cause)  
 -> **Revenue Code** (billing specific services like hospital stays)  
 -> **Total Charge** (Total expenses)

This order is also followed in Claims Processing  
Although Industry standard Codes -- Procedure Code, Diagnosis Code, Revenue Code

But it all starts with Service code.

2nd. **Pre-authorization** or **Referral requests** **->** Doctor requests from HealthPlus for specific surgery is called **Pre-authorization**  
OR PCP referral for to visit specialist like Doctor   
  
**PCP -> Refers -> Doctor -> req. from IC for specific surgery or treatment (Pre-auth.)**

3rd. **Primary Care Physician (PCP)** -> YES or No **AIAI** will tell   
**AIAI (PCP Required Indicator) +** side kick **MBR (Member Eligibility Indicator)**

4th. **Presence of multiple policies and coordinates the benefits**

Coordination of Benefits -> If John has two policies (from his mom and dad), this component ensures that claims are processed correctly, so there’s no **duplicate payment** across both policies.

**Now main thing :-**

1. **DUMD (Duplicate Claim Rule Medical)**:
   * Ensures that claims are checked for duplicates. If a claim matches certain fields like **Service Code**, **Date of Service (DOS)**, **Member details**, **Provider**, **Procedure Code**, **Diagnosis Code**, **Revenue Code**, and **Total Charge**, it may be flagged.

**Actions**:

* + **Exact Match**: If all fields match exactly, the claim is **denied**. The benefit amount becomes 0, and the provider must submit a **mandatory explanation code**.
  + **Possible Match**: If there is a partial match, a **warning** message is generated, but the claim still proceeds.

**Advantages**:

* + Prevents fraudulent or erroneous claims.
  + Saves costs for the insurance company by avoiding duplicate payments.

**Disadvantages**:

* + Delays for legitimate claims if flagged as duplicate.
  + Providers may need to spend time submitting additional documentation.

1. **DUUM (Duplicate UM Rules)**:
   * This rule checks for duplicate **Pre-authorization** or **Referral requests**. If the same request has been made twice, the system will flag it.
2. **AIAI (PCP Required)**:
   * Indicates whether a **Primary Care Physician (PCP)** is required for the member. For instance, some plans require members to get a referral from their PCP before seeing a specialist. If this rule is violated, the claim may be denied.
3. **CBCB (Coordination of Benefits)**:
   * This rule checks for the presence of multiple policies and coordinates the benefits between them. If John has two policies (from his mom and dad), this component ensures that claims are processed correctly, so there’s no **duplicate payment** across both policies.

**4th. Variable Component** -> **John Pays**

* + If John goes to a Preferred Provider (**In-network**), he pays $10 for a check-up.
  + If he goes to an **Out-of-Network** Provider, he might pay $50.
  + He doesn’t need **Pre-authorization** for basic services like check-ups but does need it for major surgeries. **Pre-authorization -> Doctor requests from HealthPlus** to ensure the surgery is medically necessary and will be covered by his insurance.

### 3 Variable Components:

1. **Service Payment (SEPY)** – Defines the copay or coinsurance indirectly based on the type of service provided.
2. **Limit (LTLT)** – The maximum limit allowed for a specific service.
3. **Deductible (DEDE)** – The amount that the individual or family must pay before the insurance company starts covering the service.

### These components vary based on 3 factors:

1. **Provider Status**
   * **PCP (Primary Care Provider)** – $5, no referral or authorization required.
   * **Specialist** – $10, referral required.
   * **Participating Provider** – $50. **(INN)**
   * **Non-Participating Provider** – $100. **(OON)**
2. **Referral Status** (PCP -> Doctor)
   * **Not Required**
   * **Required**
   * **Obtained** (Followed)
   * **Violated**
3. **Pre-authorization Status** (Doctor only)
   * **Not Required**
   * **Required**
   * **Obtained** (Followed)
   * **Violated**

**Final Scene: Putting It All Together**

By using **Facets** effectively, HealthPlus was able to create a comprehensive plan, manage claims, handle payments to providers, and even update benefits dynamically. This entire workflow was managed through **Facets Workflow**, which automated many manual processes, allowing the team to focus on delivering high-quality service to members like John.

In this way, **Facets** helped **HealthPlus** simplify its operations, reduce administrative costs, and provide better healthcare services to its members.