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Claims Data Models

Objectives

Upon successful completion of this chapter, you will be able to:

- Discuss the important columns of the major tables
- Explain the relationship of the columns to the other tables and domains as they pertain to the Facets processes
- Explain the common elements among the tables

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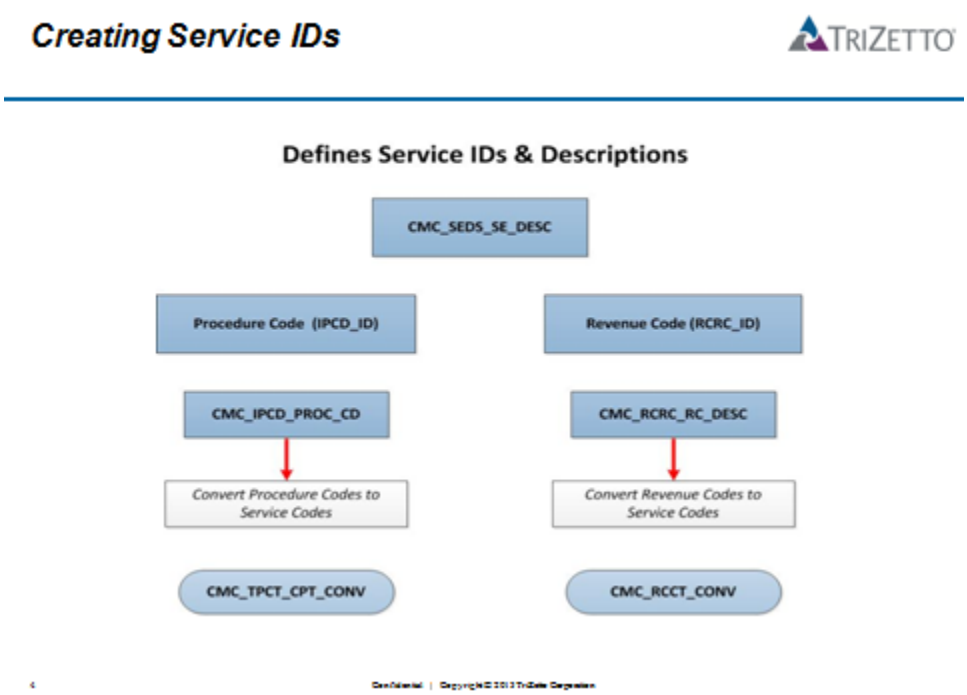
Creating Service IDs



Facets prices Procedure, Revenue, and HCPCS codes by converting each to a Service ID (SESE_ID). Several tables support the storage of procedure codes, as well as the conversion process to a SESE_ID.

Claims start at the Plan domain with the **Service Description** table, **SEDS**. Facets processes claims by services, not by procedure code. **SEDS** holds all the service codes that Facets recognizes. The MCO must map the procedure or revenue codes to the Facets services. Facets calls this mapping the Service/Procedure/Revenue Code conversion process. **SEDS**, **IPCD**, and **RCRC** are tables filled with data during the database install. Once mapping completes, the **TPCT** table displays Procedure codes and the **RCCT** table displays Revenue codes. Facets performs a look up on these tables to assign the appropriate Service ID during adjudication.

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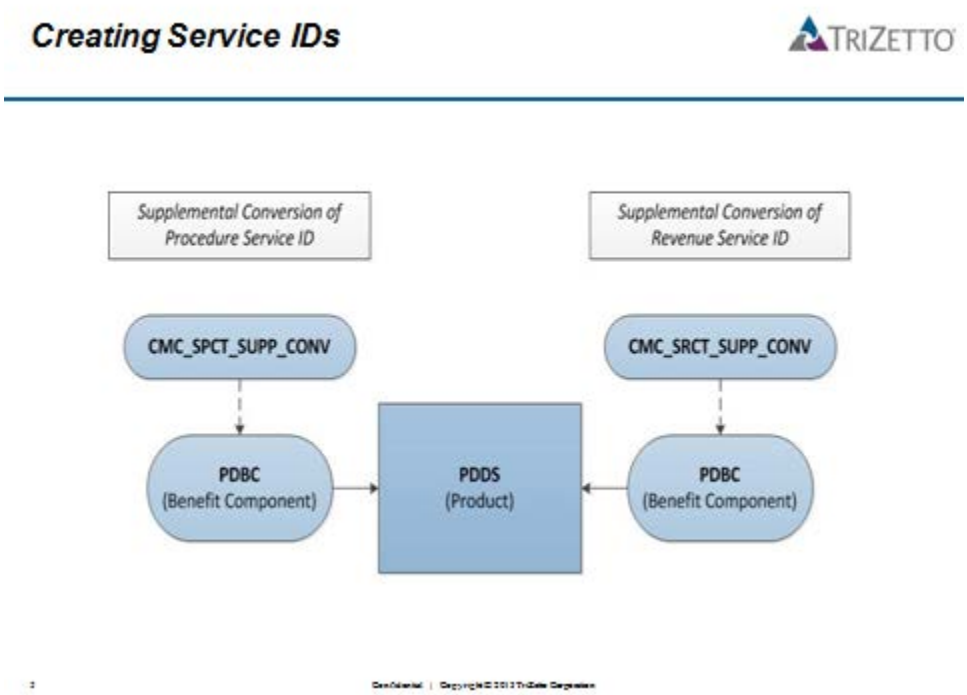

Service Codes (SESE_ID) can convert to another Service Code within the **Supplemental Conversion** tables based on the member's age, gender, diagnosis, provider specialty, or provider type. Facets also identifies a patient relationship field, **SPCT_RELATION**, on the **SPCT_SUPP_CONV** table.

In addition to the first mapping or conversion, a second mapping of the codes occurs, which results in the Supplemental Procedure/Revenue codes. Facets defines the resulting tables from this mapping, **SPCT**/**SRCT**, under PDBC in the product.

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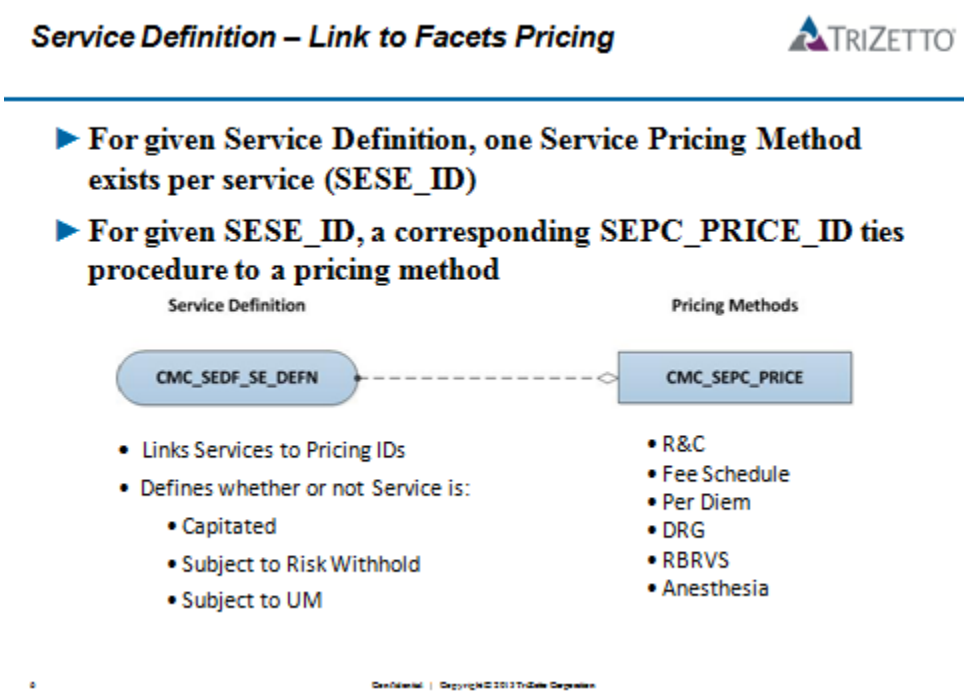
Service Definition – Link to Facets Pricing



After the procedure code converts to the Service ID, Facets looks to the **Service Definition** table (**SEDF**) and gathers more information on the service. The **SEDF** also holds a link to the **SEPC** table, which defines the pricing method for the claim.

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Service Definition – Link Facets Pricing to Payment

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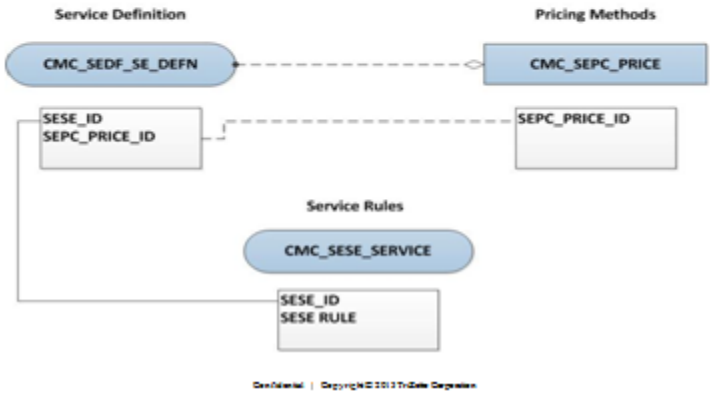
- **Service Rule Table Defines:**
  - The order Facets calculates copay, coinsurance, deductibles
  - Valid gender & age ranges
  - Amount or Counter oriented



This flowchart illustrates the link between the **SEDF**, **SEPC**, and the **SESE** tables. The **SESE** table holds the calculation method for copays, deductibles, and COB. It may also hold some restrictions on the service, such as gender or age.

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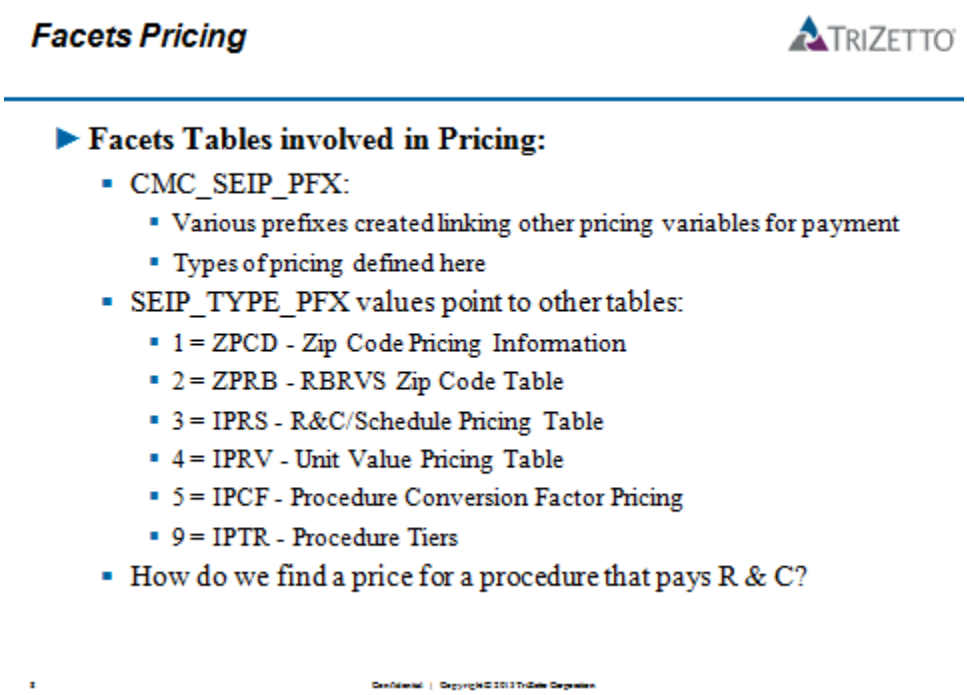
Facets Pricing



Facets pricing starts with the **SEPC** table, which stores prefixes. These prefixes point to the appropriate table that defines the dollar amount for the procedure.

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Facets Pricing

- **Prefixes determine pricing methodology Facets follows during claim adjudication:**
  - For R&C pricing example: Step 1
    - Define and store Zip code type prefix in SEIP

CMC_SEIP_PFX

SEIP_PFX	01
SEIP_TYPE_PFX	1
SEIP_PFX_DESC	Zip code definition for R&C pricing
SEIP_LOCK_TOKEN	
ATXR_SOURCE ID	

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Pricing

Pricing

- **For R&C pricing example: Step 2**
  - Define and store actual Zip code ranges in ZPCD

CMC_ZPCD_ZIP_DATA

SEIP_PFX	01	01	01
ZPCD_ZIP_PFX	070	077	077
ZPCD_EFF_DT	01/01/2010	01/01/2010	01/01/2010
ZPCD_TERM_DT	12/31/9999	12/31/9999	12/31/9999
ZPCD_AREA	001	001	002
ZPCD_LOCK_TOKEN			
ATXR_SOURCE_ID			

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Facets Pricing

Facets Pricing

- **For R&C pricing example: Step 3**
  - Define and store R&C type in SEIP (again)

CMC_SEIP_PFX

SEIP_PFX	01
SEIP_TYPE_PFX	3 (IPRS)
SEIP_PFX_DESC	R & C Pricing for 99211 - VO
SEIP_LOCK_TOKEN	
ATXR_SOURCE ID	

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Facets Pricing

- **For R&C pricing example: Step 4**
  - Define and store $ rate for procedure(s)

CMC_ZPCD_ZIP_DATA

SEIP_PFX	01	01
IPCD_ID	99211	99211
ZPCD_AREA	001	002
IPRS_EFF_DT	01/01/2010	01/01/2010
IPRS_TERM_DT	12/31/9999	12/31/9999
IPRS_RATE	$125	$100
IPRS_DISC_PCT		
IPRS_LOCK_TOKEN		
IPRS_TERM_DT		

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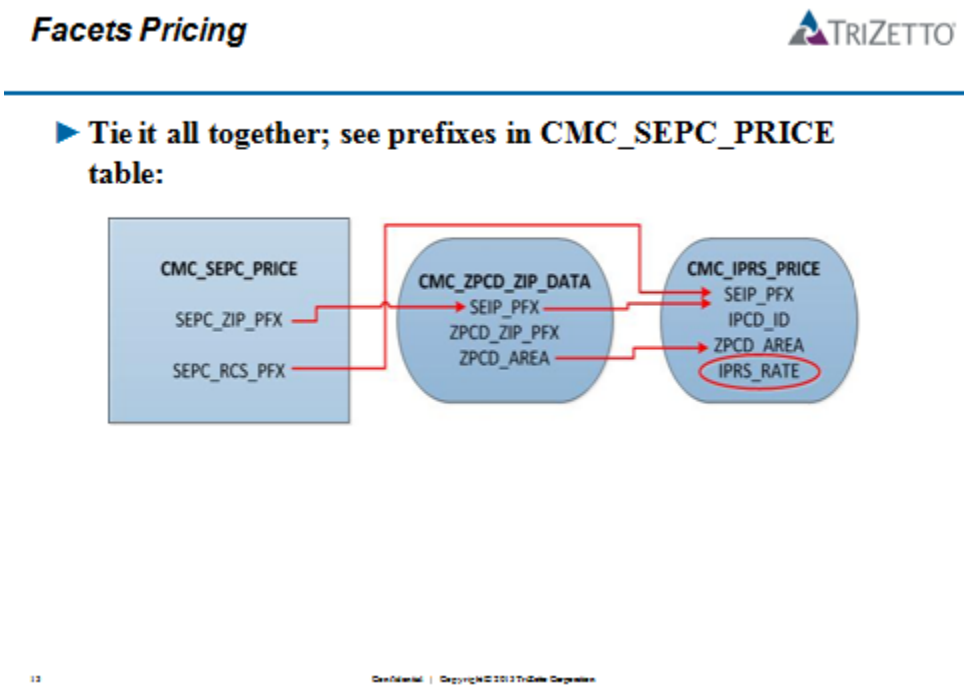

The SEPC_ZIP_PFX points to the **ZPCD** table, which determines the ZPCD_AREA based on the provider's 3 digit zip code.

The SEPC_RCS_PFX points to the **IPRS** table, which determines the SEIP_PFX to utilize during adjudication.

The ZPCD_AREA from the **ZPCD** table points to the ZPCD_AREA on the **IPRS** table in order to determine which dollar amount to use as a price during adjudication.

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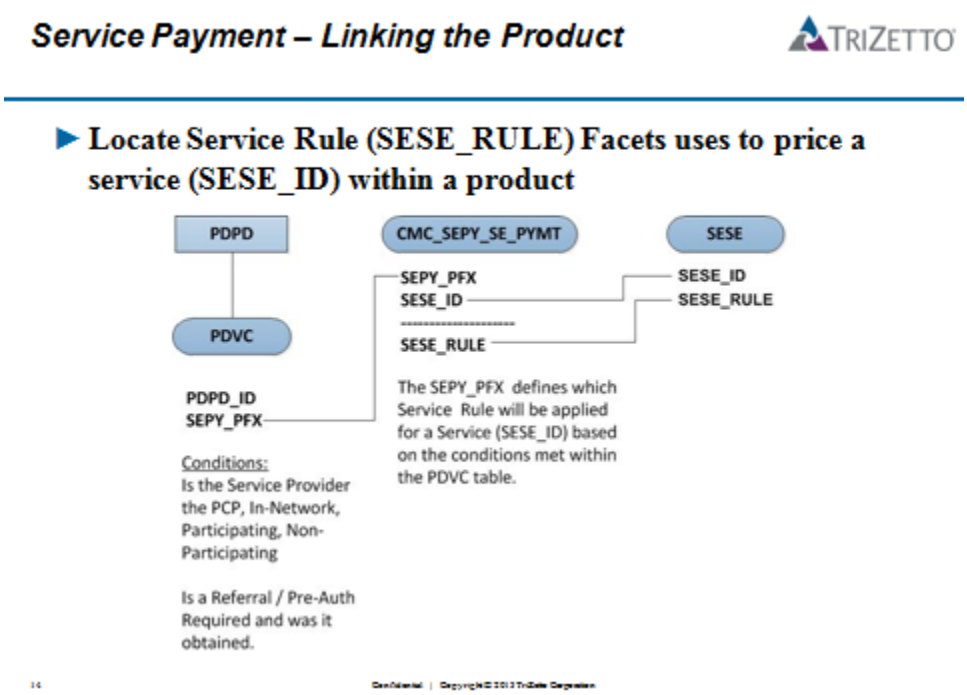
Service Payment – Linking the Product



When Facets determines a price, it looks at the conditional rows built in the **PDVC** table and matches the claim to one. That row determines which SEPY_PFX, Service Payment prefix, Facets uses when applying the SESE_RULE, Service Rule. The **SEPY** table links to the **SESE** table by SESE_ID and SESE_RULE to obtain the SESE_CALC_IND used in determining how Facets handles copays, deductibles, and coinsurance.

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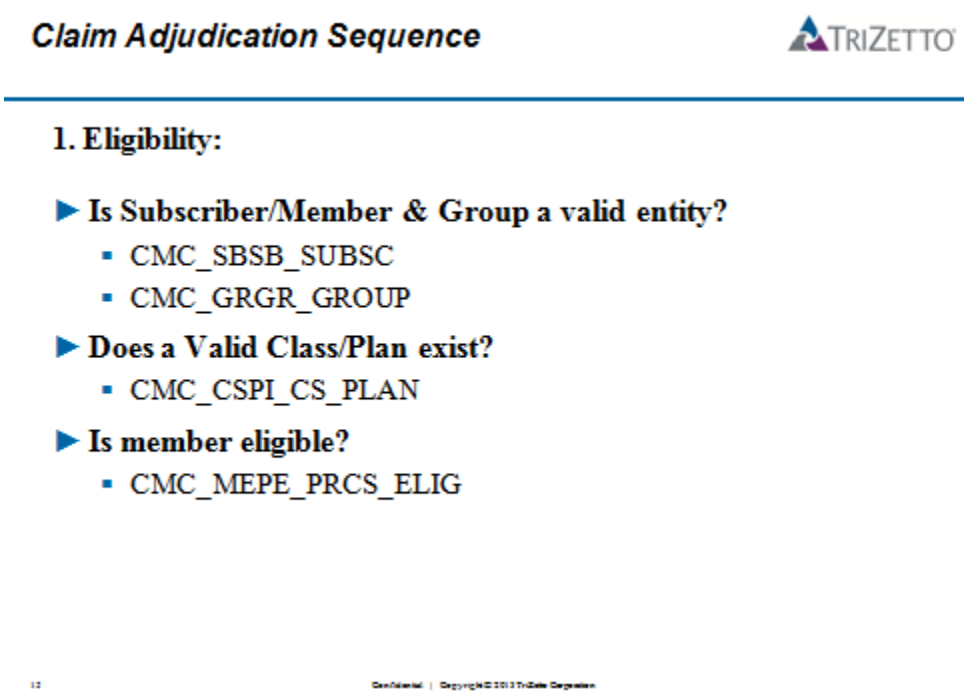
Claim Adjudication Sequence



Facets utilizes 14 steps of validation during adjudication. If one of the steps does not resolve during the adjudication process, the process stops and the claim becomes status 15 – Pended with Error. When the claims processor corrects the pended claim, Facets picks up the claim again when adjudication runs and starts the process all over again. If the claim passes all the steps, the last step becomes status 01 – Waiting for Payment Batch.

The 14 steps include:

1. Eligibility - Facets verifies that the member belongs to a valid group, a valid class/plan, and may receive benefits.

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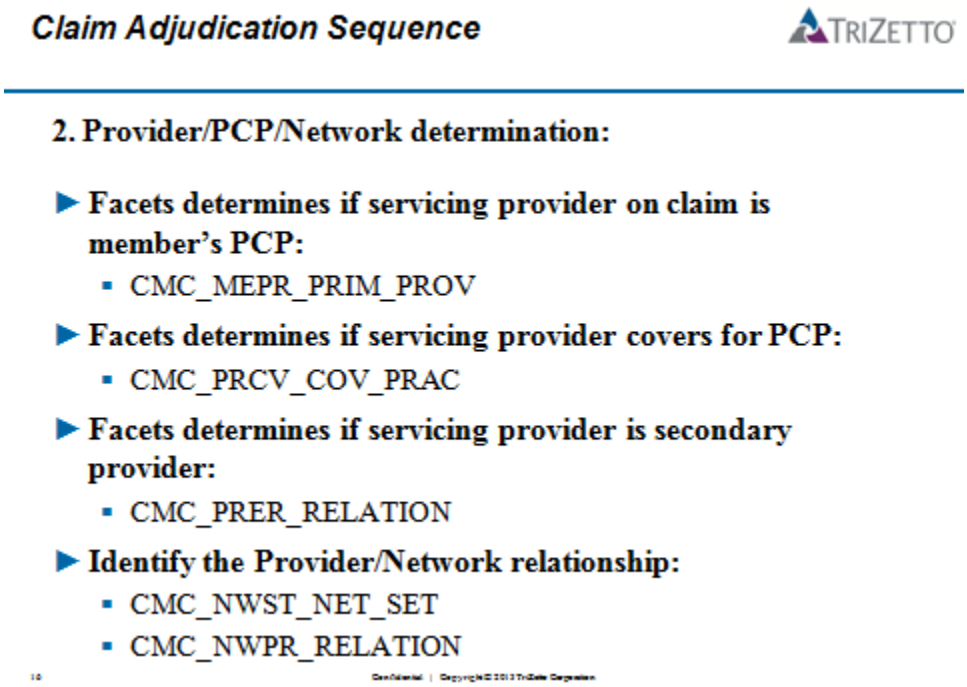

2. Provider/PCP/Network determination:
   - Facets determines if the servicing provider on the claim is the member's PCP.
   - Facets determines if the servicing provider covers for that PCP.
   - Facets determines if the servicing provider is a secondary provider.
   - Facets identifies the validity of the provider/network relationship by verifying the provider's Network Set (NWST) and Network Provider Relationship (NWPR).

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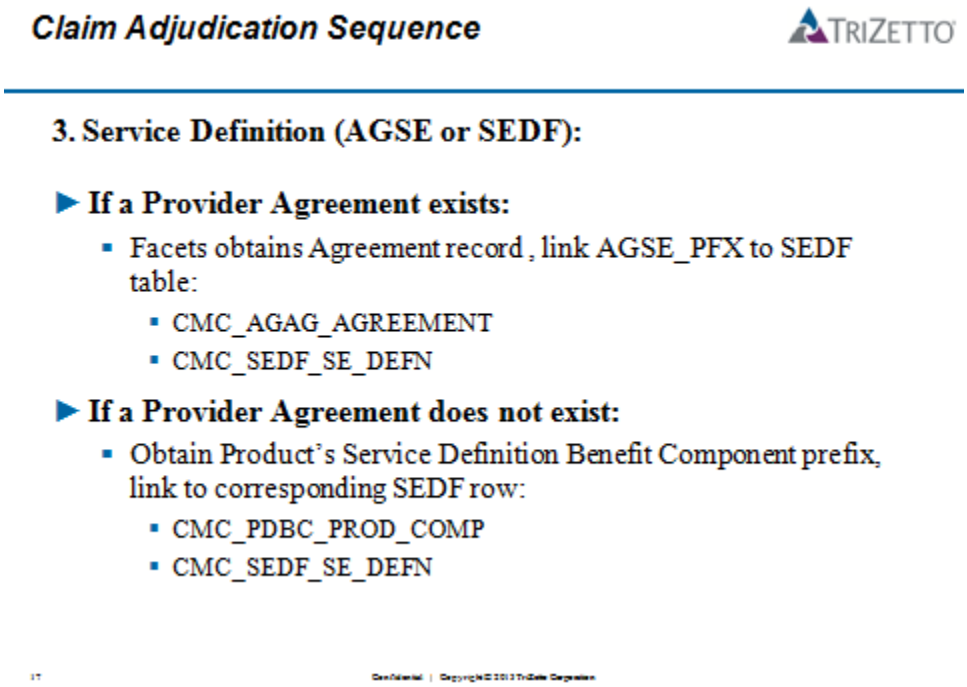

3. During claims adjudication, Facets obtains a Service Definition that in turn determines a price. If Facets finds a provider agreement, Facets retains that agreement's Service Definition (AGSE). If Facets does not find an agreement, it obtains the Service Definition from the product (SEDF).
   - The Service Definition record on the agreement (AGSE) allows the user to establish different referral, pre-authorization, pricing, capitation, and risk withholding requirements that get applied to all providers under this agreement (AGAG_ID).
   - The Service Definition record on the product points to the default or out-of-network pricing for that product.

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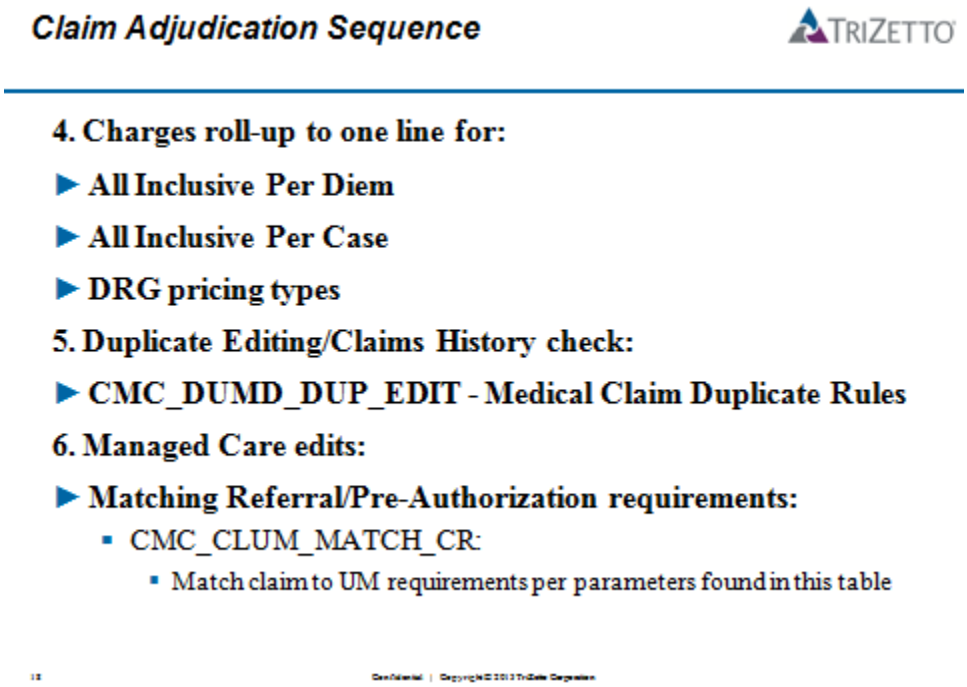

4. For All Inclusive Per Diem, All Inclusive Per Case, and DRG pricing types, charges roll up to one line (a room and board line for Per Diem and Per Case, and a *RG line for DRG pricing).
    - Roll-up pricing does not add together the units or each line of the claim.
    - Roll-up pricing occurs on services with the same date of service.
    - Roll-up pricing does not apply to services specifically excluded, as defined on the Exclusions application.

- Roll-up pricing does not override external pricing.

5. Facets checks for duplicate claim lines on the current claim and claims in history using the Duplicate Claims Rues, Medical record (CMC_DUMD_DUP_EDIT).
6. The Claims Processing applications convert the Procedure or Revenue Code to a Type of Service. Facets then uses the claim's servicing provider or Facility ID, procedure code, type of service, and diagnosis code to determine whether or not the referral and/or pre-authorization requirements exist for the claim's line item(s). If the servicing provider or facility's **Pre-authorization Required** field on the Practitioner or Facility record populates with (continued):

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continued…

- No Services, Facets bypasses the pre-authorization requirements at all other levels and assumes that pre-authorizations are not required.
- All Services, Facets assumes that pre-authorizations are required for all services regardless of the pre-authorization indicators set in any other application.
- Not Applicable, Facets proceeds to the routine as identified in steps b - e below.

Facets checks for matching pre-authorizations in the Prospective UM application if the **Pre-authorization Required** checkbox in the Procedure Edit Criteria application (found in the Criteria Maintenance application group) indicates the procedure code requires a preauthorization.

Facets checks for pre-authorizations in the Prospective UM application based on the diagnosis code on the claim if the **Pre-authorization Required** checkbox in the Diagnosis Edit Criteria application (found in the Criteria Maintenance application group) indicates the diagnosis code requires a preauthorization.

Facets checks for matching referrals and/or preauthorization in the Prospective UM application if the **Referral** and/or **Pre-authorization Required** checkboxes in the Procedure application (found in the Medical Provider Agreement application group) indicate the procedure code requires a preauthorization and/or referral.

Facets checks for matching referrals and/or pre-authorizations in the Prospective UM application if the **Referral** and/or **Pre-authorization Required** checkboxes for a Type of Service are checked in the Service Definition application. Facets stores the Service Definition records in two places:

- Facets checks for a Service Definition record on the provider's agreement first (AGSE).
- If Facets does not find an agreement, it checks for a Service Definition record on the member's product (SEDF).
  - Facets provides an option on the Service Definition application (the AGSE or SEDF) to waive the referral requirements for PCP ordered services. In this instance, Facets must identify the PCP as the referring provider on the claim.

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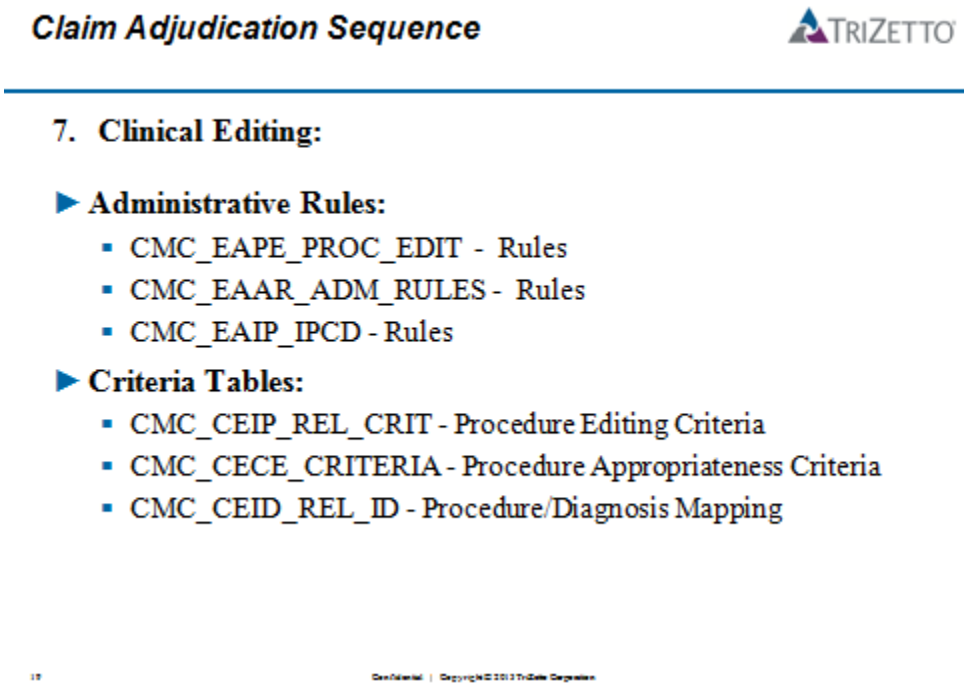

7. In claims adjudication, Facets reads the **Plan** table (Administrative Parameters) to obtain the clinical editing criteria. In the ***Processing Actions*** section of the Clinical Editing Administrative Rules application, users may customize clinical edits; therefore services can bypass, disallow, or generate a warning message when encountering an edit. In the case of subset and redundant edits, charges combine from the edited procedure line items into the primary procedure line item. In the case of secondary edits, the secondary penalty percentage prices against the calculated allowable priced amount of the line item. This refers to the priced amount of the line, not the charges. The outcome of these edits display in the ***Clinical Edits*** section tabs of the Medical and Hospital Claims Processing and Pre-pricing applications.

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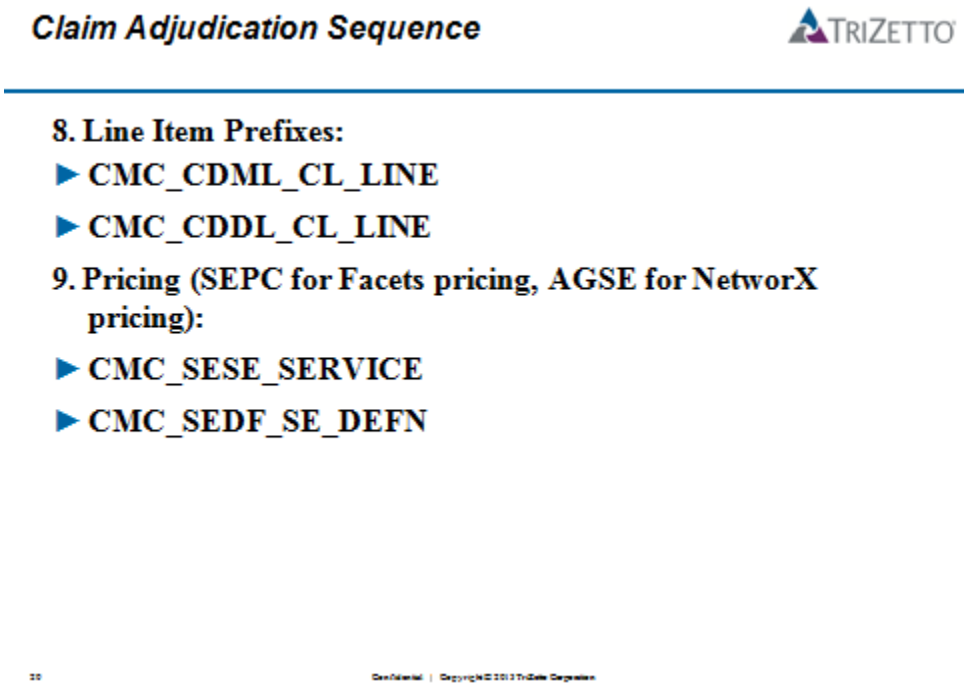

8. Facets populates the ***Product and Prefixes*** dialog box (opened from the **View** menu) with a complete listing of all the product prefixes used during the adjudication routine when a claim is processed, including the prefixes used from the appropriate product Variable Components.
9. In claims adjudication, Facets edits the Procedure and/or Revenue codes from the claim against supplied data tables. Users create Service IDs by mapping groups of CPT-4/Revenue codes using conversion tables. The Service ID represents the definition used for pricing the service. The **Service Rule** table (**SESE**) and **Service Definition** table (**SEDF**) establish the specific rules and parameters set to adjudicate claims. Service Pricing does not link to the Product as a component. Instead, Service Pricing IDs link to Service IDs on the Service Definition. They link directly to a product as a component as well as to a provider's agreement.

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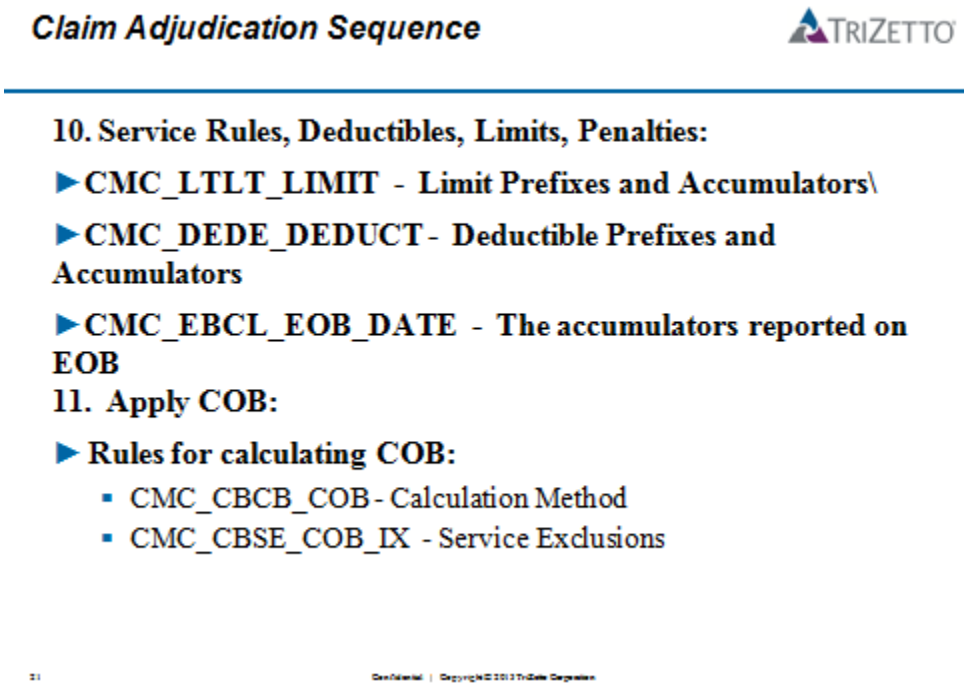

10. Service rules help Facets adjudicate payment based on several parameters. A user may apply multiple service rules (SESE_RULES) to a Service ID (SESE_ID). A Service Rule establishes the calculation method of the service, any claims processing edits, penalty types and amounts, and service tiers. At a high level, Facets determines how services price:
    - Will Medical claims price by reasonable and customary (R&C) rates or fee schedules?
    - Will Room and Board services reimburse by Per Diem/Per Case or DRG rates?
11. Users select a calculation method from a variety of options in order to administer COB provisions properly. One product can require COB to coordinate up to the higher of the two carriers allowable amounts, while another product administered by the same carrier, can require coordination to their own (i.e., Facets) allowable amount or even the submitted charges on the claim.

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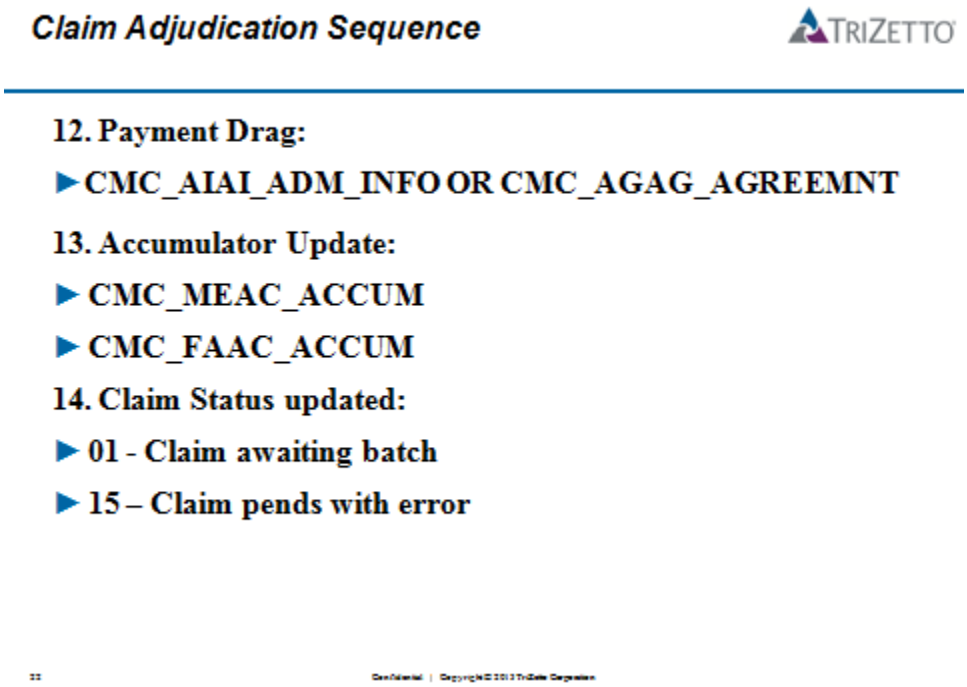

12. Payment Drag alters the timing of when a provider's claim runs through the claims payment batch. Payment Drag at the agreement level supersedes Payment Drag at the Administrative Information level found on the Product.
13. Accumulators allow MCOs to do the following:
    - Track benefits by either money or number of visits (counter).
    - Track benefits at the member or family level.
    - Identify accumulator buckets for all members of a specific product.
    - Track accumulations by a specified amount of time (yearly or by lifetime).
    - Track the amount of money spent or saved through Coordination of Benefits (COB).
14. Facets updates the status of the claim.

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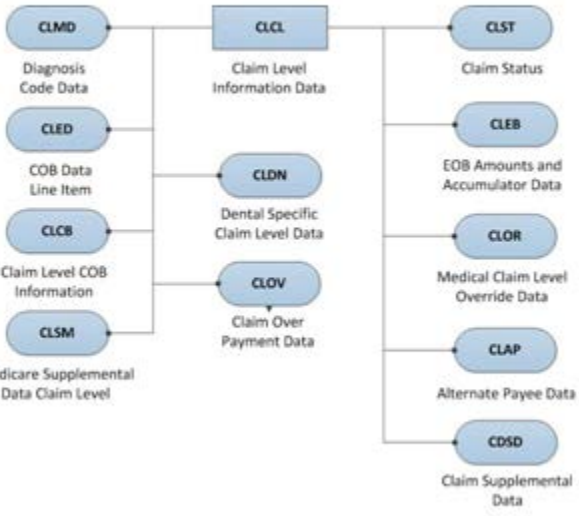
Claim Summary Tables



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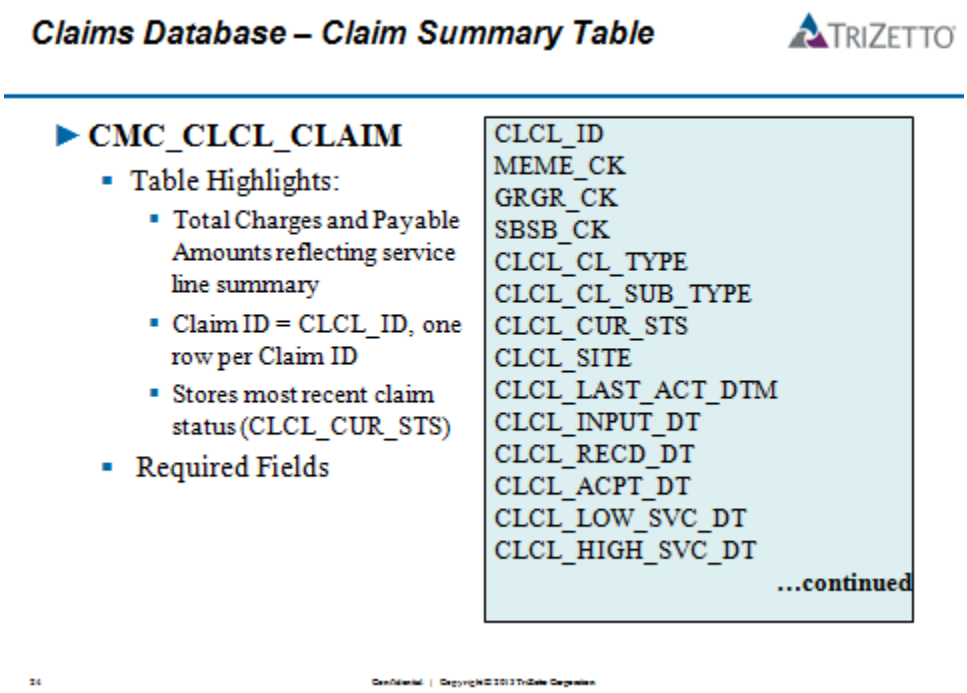
Claims Database – Claim Summary Table



The **Claim Summary** table, **CLCL**, represents the main table in the Claims domain.

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continued…

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

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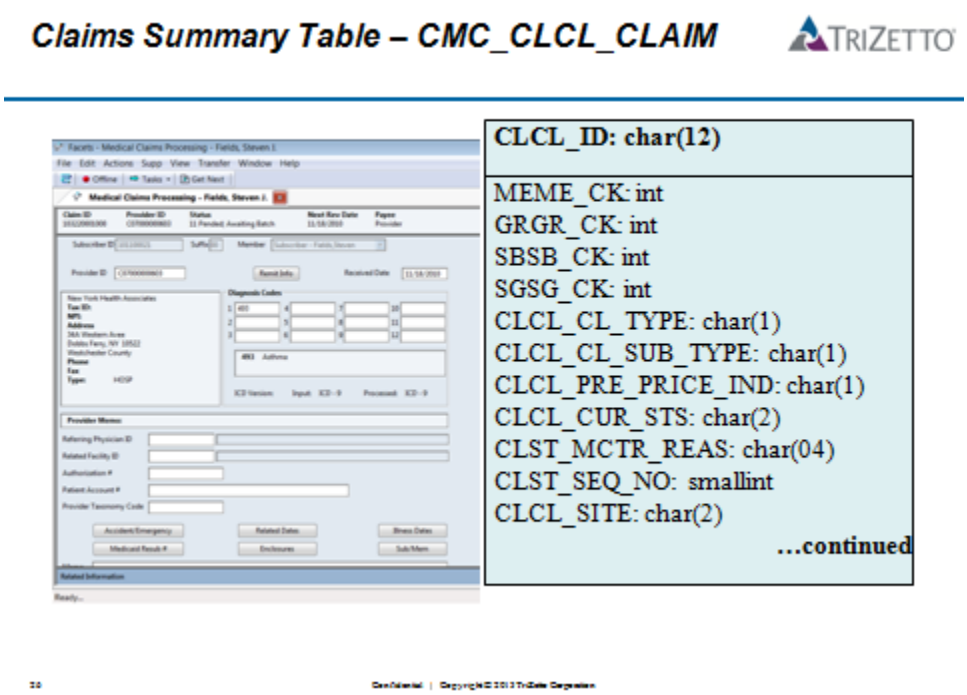
Claims Summary Table – CMC_CLCL_CLAIM



This table stores the base claim level information for both Medical and Hospital claims, the Claim ID originates here. This table stores indicative information including the member, provider, PCP, and plan in effect, as well as the input and received dates, and the status of the claim.

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continued…

CLCL_LAST_ACT_DTM: datetime

CLCL_INPUT_DT: datetime

CLCL_RECD_DT: datetime

CLCL_ACPT_DTM: datetime

CLCL_PAID_DT: datetime

CLCL_NEXT_REV_DT: datetime

CLCL_LOW_SVC_DT: datetime

CLCL_HIGH_SVC_DT: datetime

CLCL_ID_ADJ_TO: char(12)

CLCL_ID_ADJ_FROM: char(12)

CLCL_ID_CRTE_FROM: char(12)

CSPD_CAT: char(1)

PZAP_ID: char(4)

CSCS_ID: char(4)

CSPI_ID: char(8)

PDPD_ID: char(8)

MEPE_FI: char(1)

MEPE_PLAN_ENTRY_DT: datetime

CLCL_COBRA_IND: char(1)

CLCL_ME_AGE: smallint

MEME_REL: char(01)

MEME_SEX: char(1)

MEME_RECORD_NO: char(11)

MEME_HICN: char(12)

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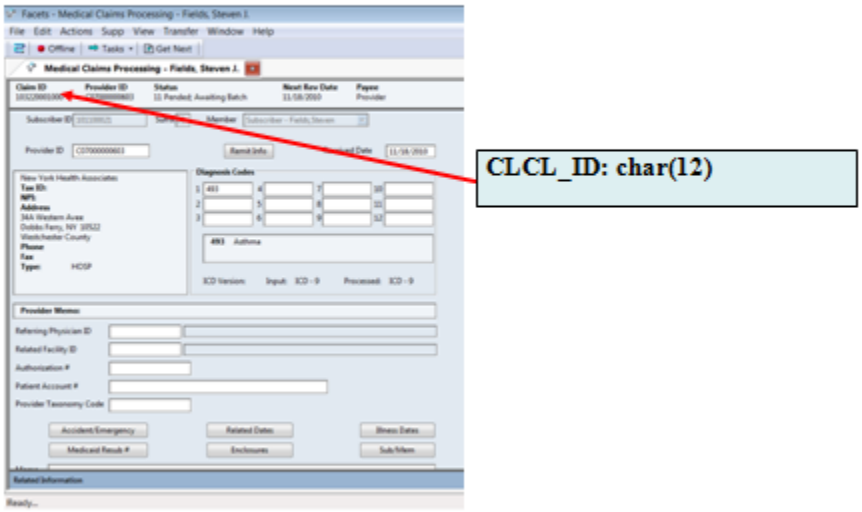
Claims Summary Table – CMC_CLCL_CLAIM



The Claim ID (CLCL_ID) identifies a claim record and the corresponding data. The Claim ID separates into a ten-character ID and a two-character suffix. The Suffix starts at 00. The user can use alphanumeric values for the key, but should avoid special characters such as brackets, percent signs, dollar signs, etc.

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Claims Summary Table – CMC_CLCL_CLAIM

CLCL_CL_TYPE: char(1)

CLCL_CL_SUB_TYPE: char(1)

The system generated value of CLCL_CL_TYPE identifies the type of claim (e.g. medical or dental). Values include:

- M – Medical
- D – Dental
- V - Vision
- F – FSA
- E – Encounter
- R – Reimbursable

The CLCL_CL_SUB_TYPE indicates the level below the claim type. Values include:

- D – Dental
- C – FSA Dependent Care
- F – Healthcare FSA
- M – Medical
- H – Hospital
- V - Vision

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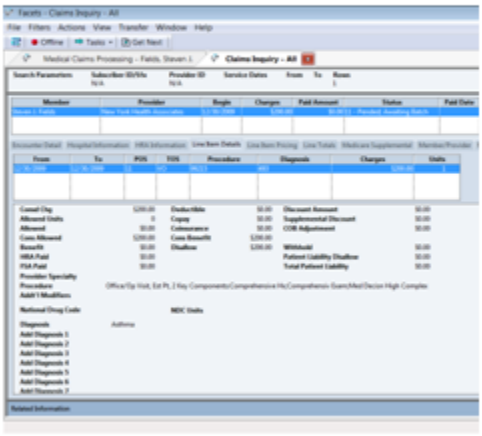
Claims Summary Table – CMC_CLCL_CLAIM



CLCL_PRE_PRICE_IND: char(1)

The CLCL_PRE_PRICE_IND indicates if a claim pre-priced and adjudicated, pre-priced only, or adjudicated only. Values include:

Type	Meaning
C	Identifies that the claim prepriced and adjudicated.
D	Identifies dental claim predetermination.
E	Identifies ITS Host ECRP.
H	Identifies ITS Home.
I	Identifies ITS Host POS.
None	Identifies that the claim adjudicated but did not preprice.
P	Identifies that the claim prepriced.
S	Identifies ITS Host.
T	Identifies ITS Home ECRP.
X	Identifies Process Host Determination Logic.

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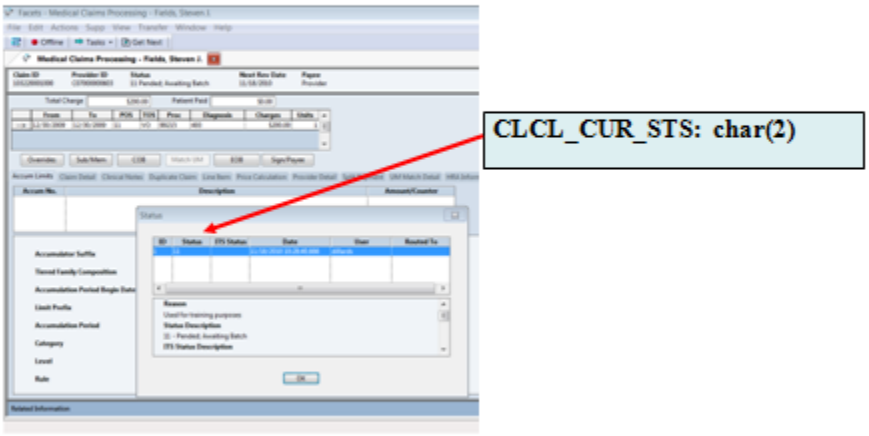
Claims Summary Table – CMC_CLCL_CLAIM



The system generated code, CLCL_CUR_STS, identifies the current status of the claim. A total of 12 values complete this column, such as 01 - Claim Accepted; Awaiting Batch.

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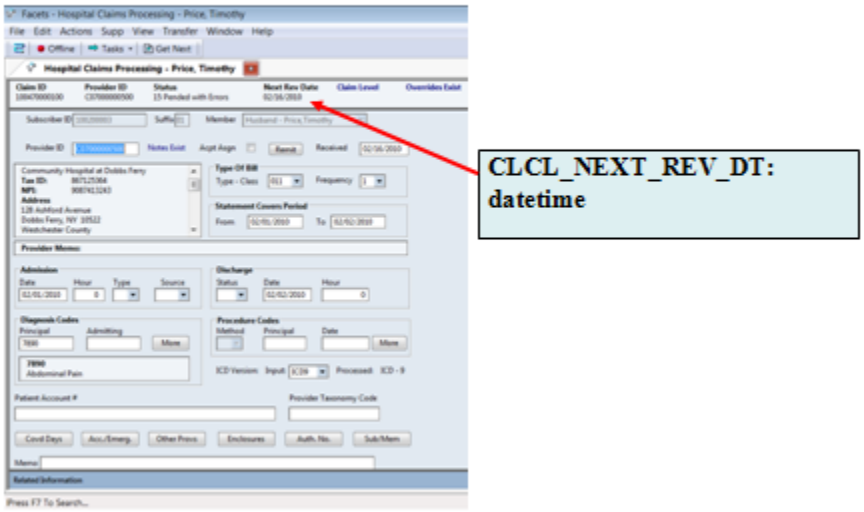
Claims Summary Table – CMC_CLCL_CLAIM



CLCL_NEXT_REV_DT indicates the next review date of a pended claim (status 11) and is required if the claim is pended.

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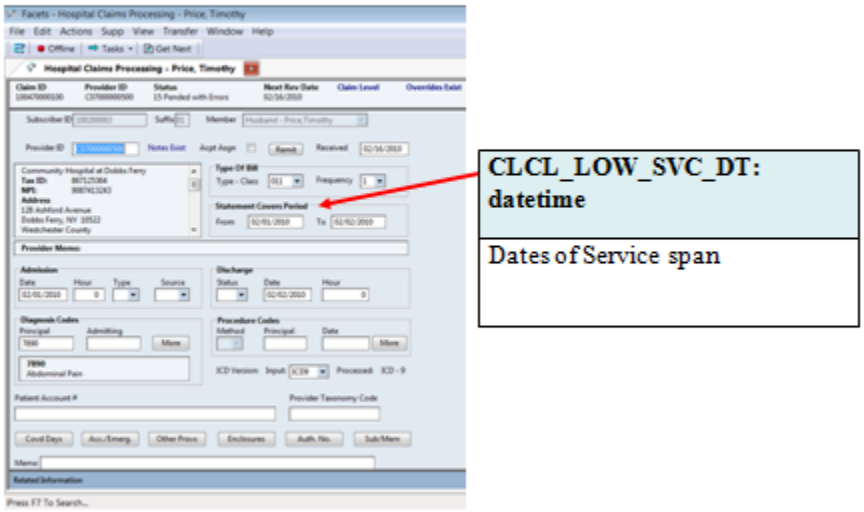
Claims Summary Table – CMC_CLCL_CLAIM



The CLCL_LOW_SVC_DT and the CLCL_HIGH_SVC_DT provide the range of dates for this claim.

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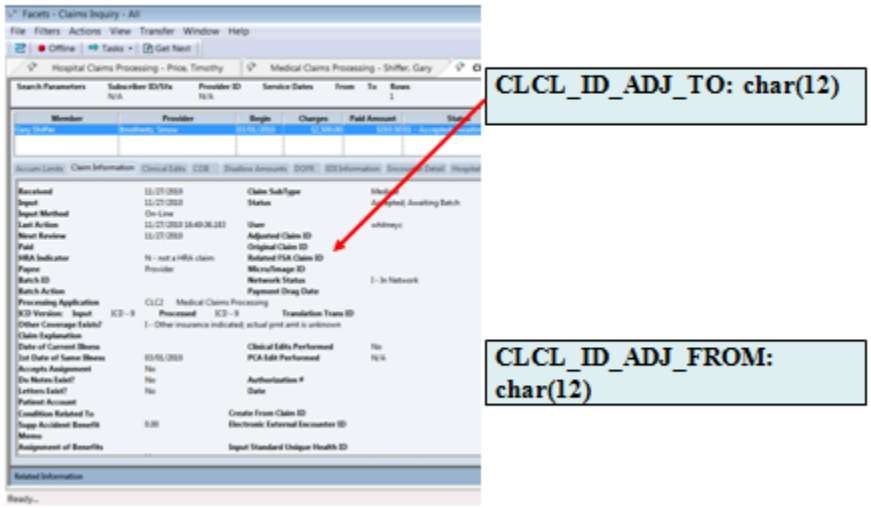
Claims Summary Table – CMC_CLCL_CLAIM



The system generated entry of CLCL_ID_ADJ_TO includes the 10 position base claim number as the CLCL_ID plus the 2 position segment, which varies.

These columns identify the original claim number and the claim number the claim adjusted to if the user completed an adjustment on the claim. The last two digits on the claim vary when the user makes adjustments. A 00 identifies the original claim, 01 identifies the first adjustment, etc.

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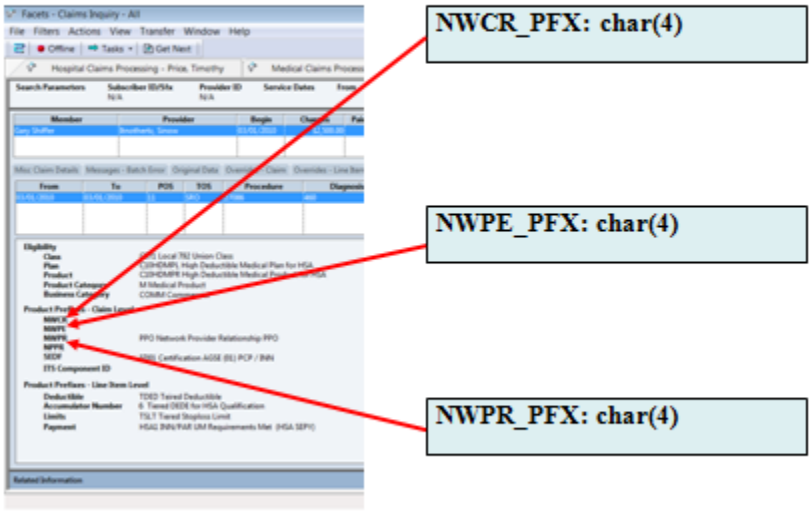
Claims Summary Table – CMC_CLCL_CLAIM



The NWPE_PFX, NWCR_PFX, and the NWPR_PFX identify the Network Provider Capitation Relationship prefix used in adjudicating this claim.

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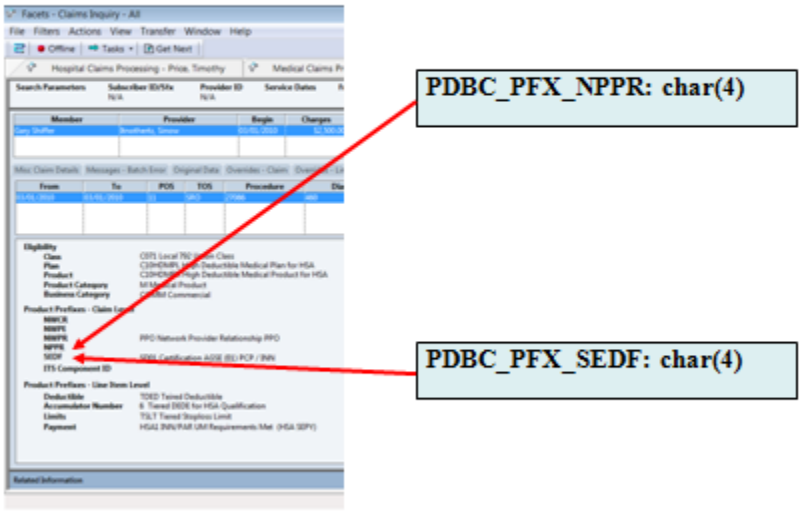
Claims Summary Table – CMC_CLCL_CLAIM



The PDBC_PFX_NPPR and PDBC_PFX_SEDF identify the non-participating provider relationship and Service Definition prefixes used in adjudication.

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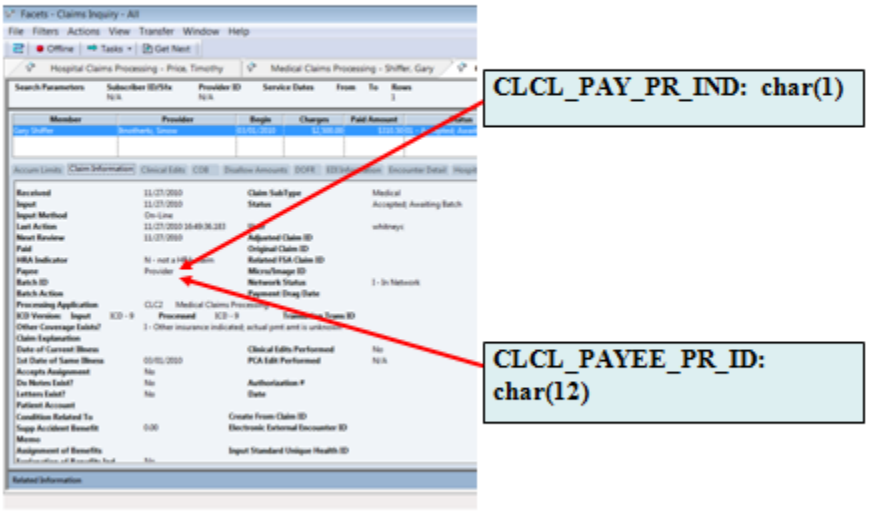
Claims Summary Table – CMC_CLCL_CLAIM



Type	Meaning
CLCL_PAY_PR_IND	This indicates the entity designated as the payee for the claim.
A	This indicates the alternate payee.
P	This indicates the provider.
S	This indicates the subscriber.
For Medical/Hospital claims	This allows only one checkmark for either the provider, member, or the alternate payee.
CLCL_PAYEE_PR_ID	This indicates the valid Provider ID on **PRPR** table. Facets determines whether payment is capitated or fee for service. It then must access either the PRPR_PAY_CL_IND or PRPR_PAY_CAP_IND entries on the **Provider** (**PRPR**) table to obtain the appropriate Payee Provider ID.

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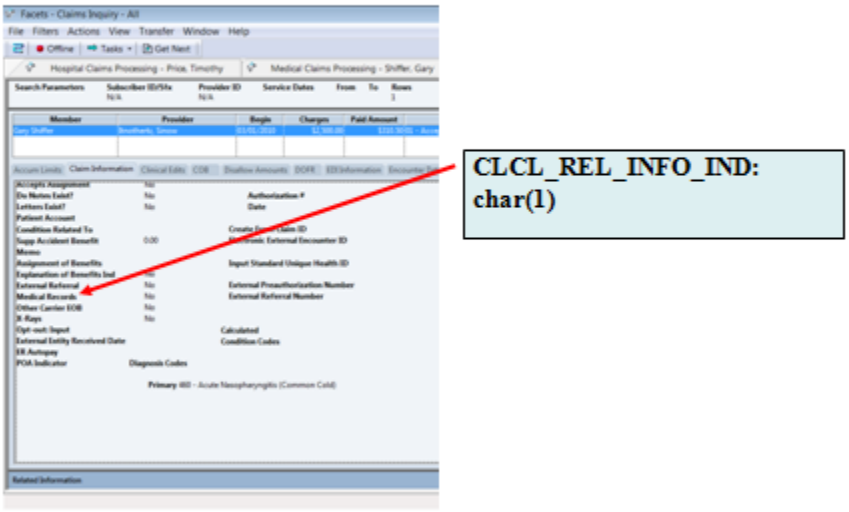
Claims Summary Table – CMC_CLCL_CLAIM



Type	Meaning
CLCL_REL_INFO_IND	This indicates authorization of any required medical record information by the servicing provider.
C	This indicates a signature is on claim form.
N	This indicates no signature is on file.
S	This indicates a signature is on file at the provider site.

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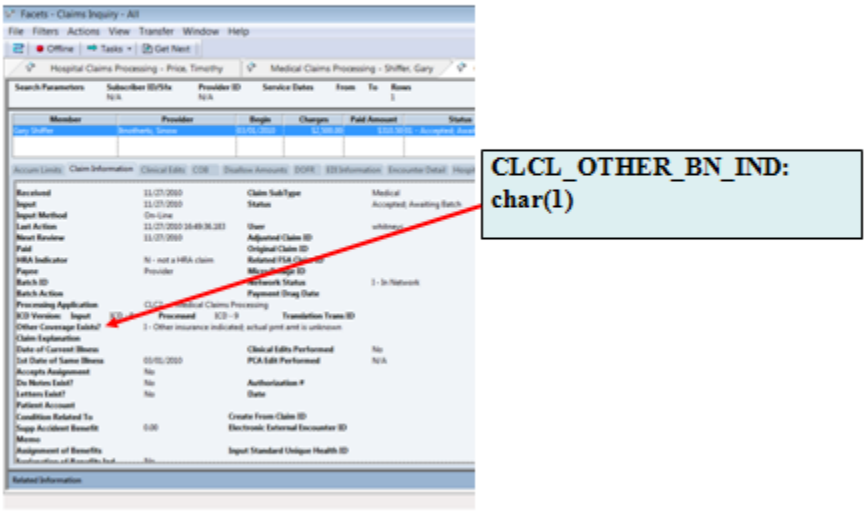
Claims Summary Table – CMC_CLCL_CLAIM



Indicator	Meaning
CLCL_OTHER_BN_IND	This indicates if other benefits apply to this claim only.
I	This indicates other insurance; the actual payment amount is unknown.
N	No
Y	Yes
U	This indicates other reported insurance; info gets sent.

This indicator contains no functionality and does not link COB to a member. Therefore, if Facets finds other insurance coverage for the member, that coverage must reflect on the member's record (MECB).

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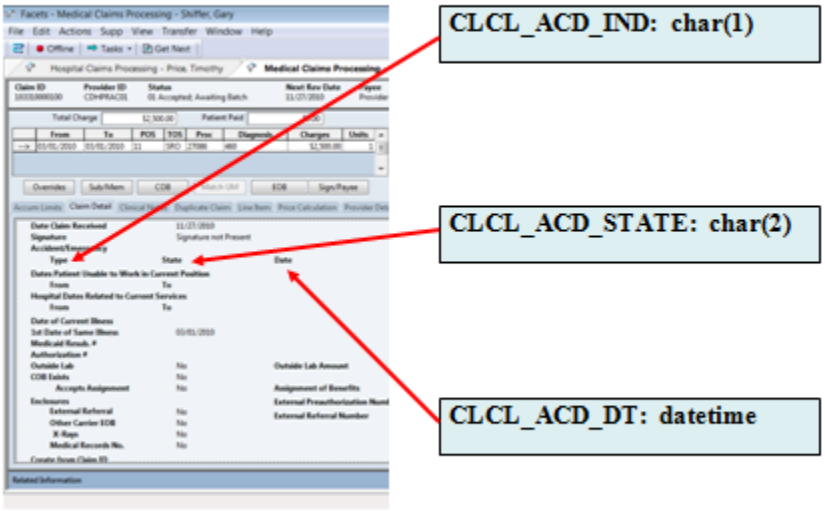
Claims Summary Table – CMC_CLCL_CLAIM



Type	Meaning
CLCL_ACD_IND	This identifies whether the claim relates to an accident or emergency illness.
CLCL_ACD_STATE	This identifies if this claim relates to an automobile accident. If so, select the state in which the accident occurred. Facets requires a valid state code entry only when CLCL_ACD_IND = A (Auto Accident).
CLCL_ACD_DT	This identifies the user defined date entry in MM/DD/YY format. Facets requires this entry if CLCL_ACD_IND doesn't = blank.

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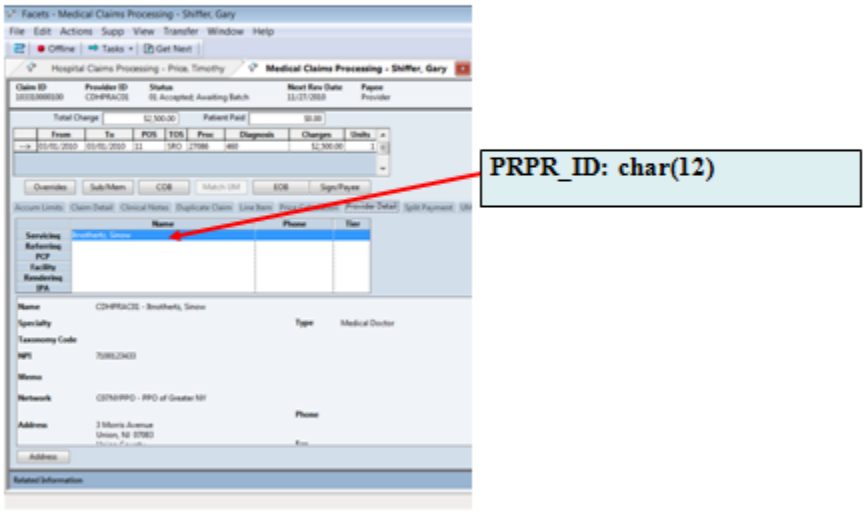
Claims Summary Table – CMC_CLCL_CLAIM



Type	Meaning
PRPR_ID	Identifies the Servicing Provider of the claim, which must be a valid PRPR_ID on the **PRPR** table.

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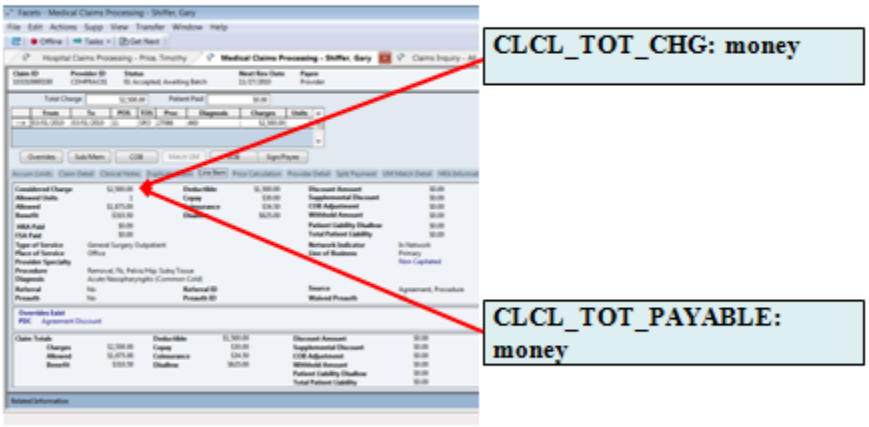
Claims Summary Table – CMC_CLCL_CLAIM



Column	Meaning
CLCL_TOT_CHG	This identifies the sum of all CDML_PAID_AMT's for the line items on the claim.
CLCL_TOT_PAYABLE	This identifies the sum of the line item charges (CDML_CHG_AMT) to this column entry.

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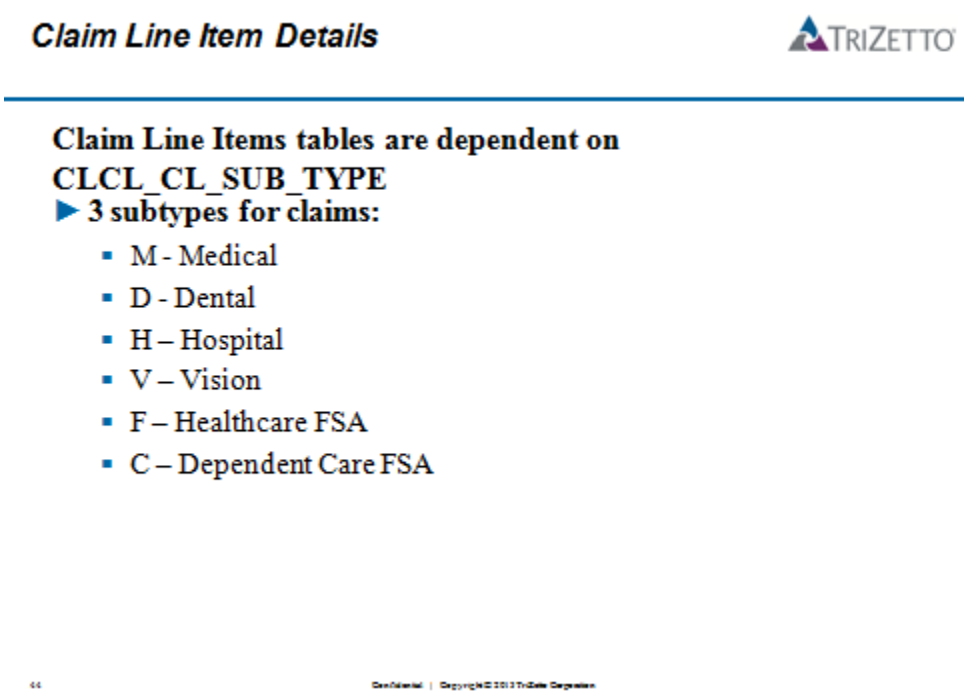
Claim Line Item Details



- For Medical claims, (CLCL_CL_TYPE=M and CLCL_CL_SUB_TYPE=M or H) use CMC_CDML_CL_LINE.
- For UB04 Hospital claims, (CLCL_CL_TYPE=M and CLCL_CL_SUB_TYPE=H) use CMC_CLHP_HOSP.

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Claim Line Item Details

- **Line Items for Medical claims include:**
  - Service dates
  - Place of service (POS)
  - Type of service (TOS)
  - Provider ID (PRPR_ID)
  - Diagnosis code (IDCD_ID) fields expanded for ICD10 values
  - Procedure code (IPCD_ID) fields expanded for ICD10 values
  - Service ID (SESE_ID)
  - Service Rule (SESE_RULE)

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Claim Line Item Details

- **Line Items for UB04 Hospital claims include:**
  - Bill Class Type (CLHP_BILL_CLASS)
  - Frequency code (CLHP_FREQUENCY)
  - Admission date (CLHP_ADM_DT)
  - Admitting Provider ID (CLHP_PRPR_ID_ADM)
  - Procedure code (CLHP_IPCD_METH)

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This table links to four other tables that supply additional information. They include:

Table	Meaning
CLCL_CLHC_COND_CODE	This table stores information that identifies the hospital specific condition code for the hospital claim submission.
CMC_CLHO_OCC_CODE	This table stores the UB04 occurrence information including the 2 byte code indicating the specific medical, accident, or insurance related occurrence and the from and to date. A sequence number allows multiple entries to exist.
CMC_CLHI_PROC	This table stores the type of procedure code (CPT4, ICD-9) and the actual procedure code used on a hospital claim.
CMC_CLVC_VAL_CODE	This table stores the entry of optional value codes associated with Hospital Claims Processing. Facets stores these values, when captured, for informational purposes only.

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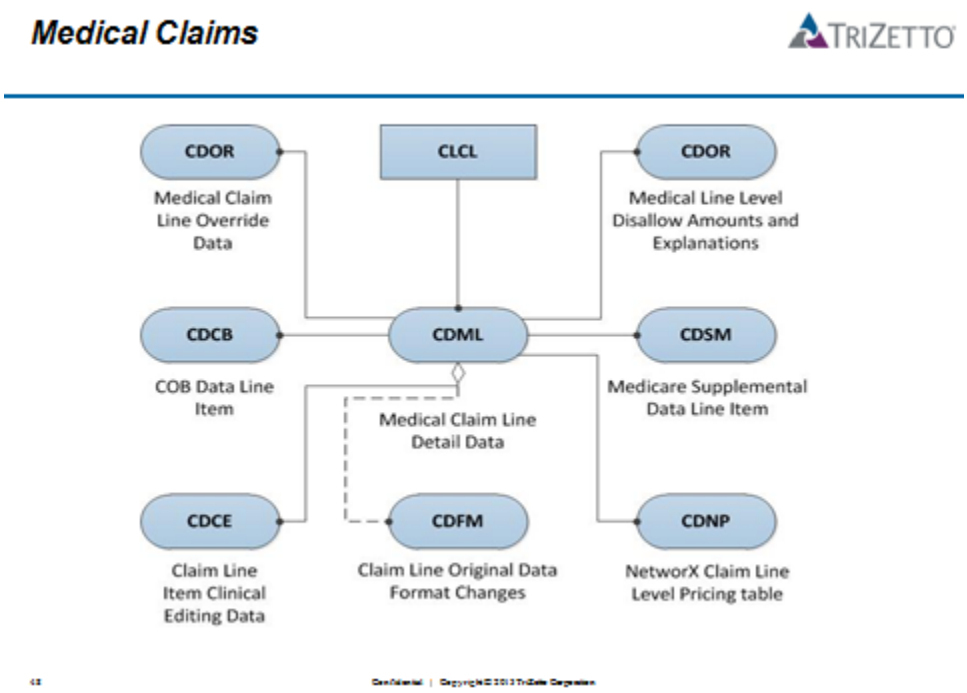
Medical Claims



This displays the structure of the claim line, CMC_CDML_CL_LINE, with its seven supporting tables:

Table	Meaning
CMC_CDOR_LI_OVR	This table stores information for each medical line item level override along with the corresponding explanation code. It also stores the date and the type of override
CMC_COCB_LI_COB	This table stores information on the Coordination of Benefits (COB) at the claim line item level, including the amount, savings, and type of coordination that exists with each line item on the claim.
CMC_COCE_LI_EDIT	This table stores claim line item level clinical editing information.

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Table	Meaning
CMC_CDFM_FI_ORIG	This table stores the original line items submitted on a claim where clinical editing performed a format change resulting in new line item(s) considered for payment.
CMC_CDMD_LI_DISALL	This indicates the disallow types, amount, and explanations for the Facets medical claim line item.
CMC_CDSM_LI_MSUPP	This table stores the line item level Medicare Supplemental data.
CMC_CDNP_NWX_PRICNG	Facets uses this table to store pricing data when invoking the NetworX Enhanced Pricer routine.

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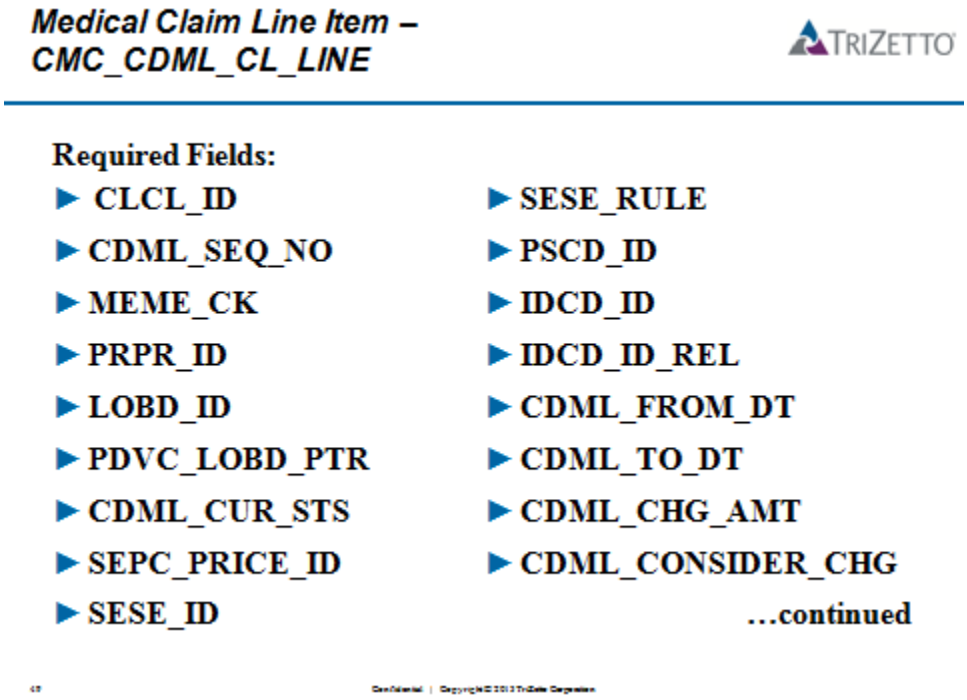
Medical Claim Line Item – CMC_CDML_CL_LINE



This table stores detail information for medical claim line items. It serves as the primary table when reporting information on claim line data, including the date of service, type and place of service, service rendered, and procedure code/modifiers. It also includes the outcome of the claims processed such as the price used, disallowed, and benefit amounts. It links to the indicative claim information via the CLCL_ID.

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Medical Claim Line Item – CMC_CDML_CL_LINE

Required Fields – continued…

- CDML_ALLOW
- CDML_UNITS_ALLOW
- CDML_DED_AMT
- CDML_DED_ACC_NO
- CDML_COPAY_AMT
- CDML_COINS_AMT
- CDML_RISK_WH_AMT
- CDML_PAID_AMT
- CDML_DISALL_AMT
- CDML_AG_PRICE
- CDML_PF_PRICE
- CDML_IP_PRICE
- CDML_SE_PRICE
- CDML_CL_NTWK_IND
- CDML_REF_IND
- CDML_PC_IND
- CDML_CAP_IND

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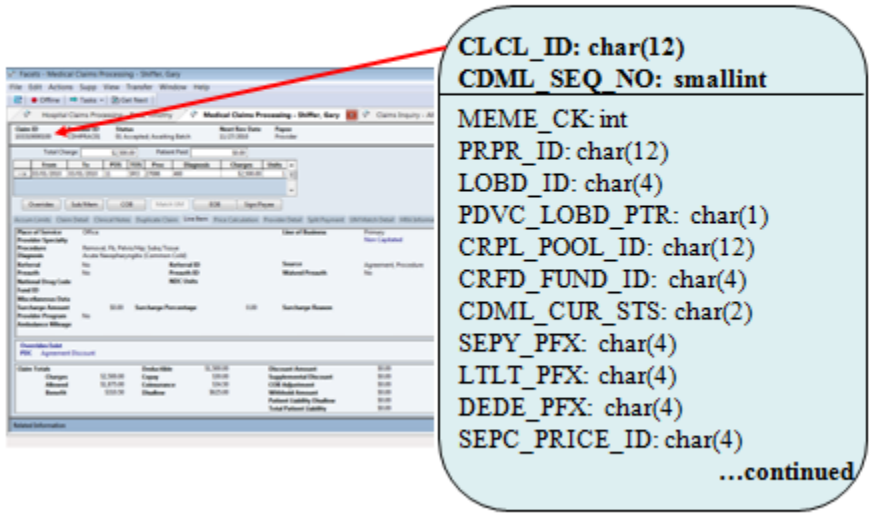
Medical Claim Line Item – CMC_CDML_CL_LINE



Each claim line carries the same CLCL_ID, the main identifier of the claim.

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continued…

RCRC_ID: char(4)

SESE_ID: char(4)

SESE_RULE: char(3)

PSCD_ID: char(2)

IPCD_ID: char(7)

IDCD_ID: varchar(10)

IDCD_ID_REL: varchar(10)

CDML_FROM_DT: datetime

CDML_TO_DT: datetime

CDML_ROOM_TYPE: char(2)

CDML_CHG_AMT: money

CDML_ANES_PHY_STAT: char(1)

CDML_HCPCS_AMT: money

CDML_CONSIDER_CHG: money

CDML_ALLOW: money

CDML_UNITS: smallint

CDML_UNITS_ALLOW: smallint

CDML_DED_AMT: money

CDML_DED_ACC_NO: smallint

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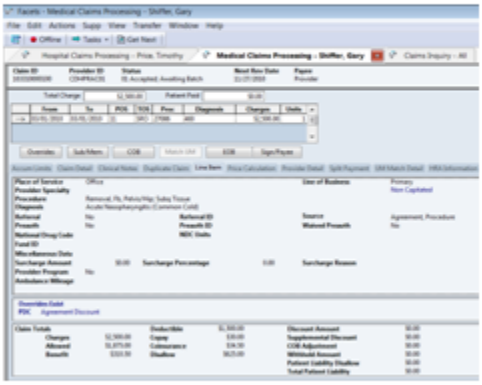
Medical Claim Line Item – CMC_CDML_CL_LINE



CDML_SEQ_NO: smallint

Type	Meaning
CLMD_SEQ_NO	This illustrates the identifier assigned by Facets to make the line item within the claim unique to the system.

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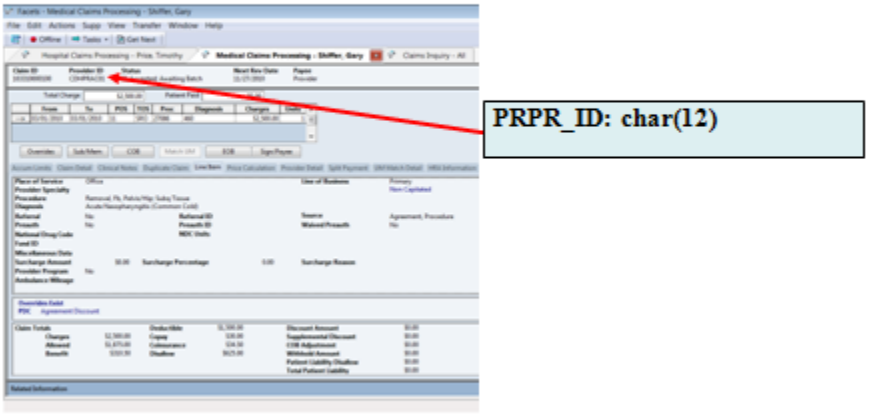
Medical Claim Line Item – CMC_CDML_CL_LINE



Type	Meaning
PRPR_ID	This identifies the Provider Identification Number of the servicing provider.

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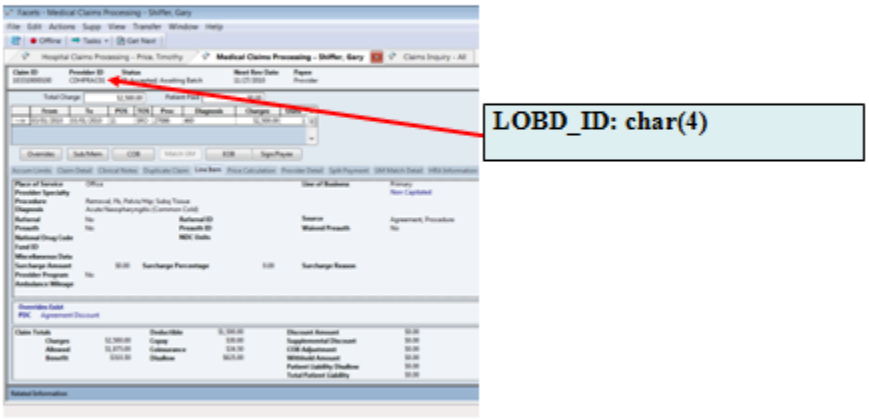
Medical Claim Line Item – CMC_CDML_CL_LINE



Type	Meaning
LOBD_ID	The user selects the code that identifies a specific line of business for the MCO. Facets uses these codes to associate separate business lines with specific benefit products, individual/combined claim checks and payments, and capitation adjustments.

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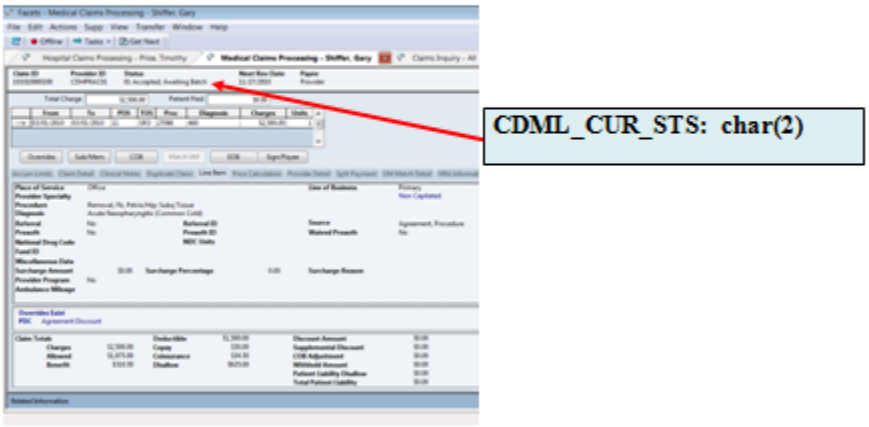
Medical Claim Line Item – CMC_CDML_CL_LINE



Type	Meaning
CDML_CUR_STS	This indicates the current status of the claim, the same status as the **CLCL** table.

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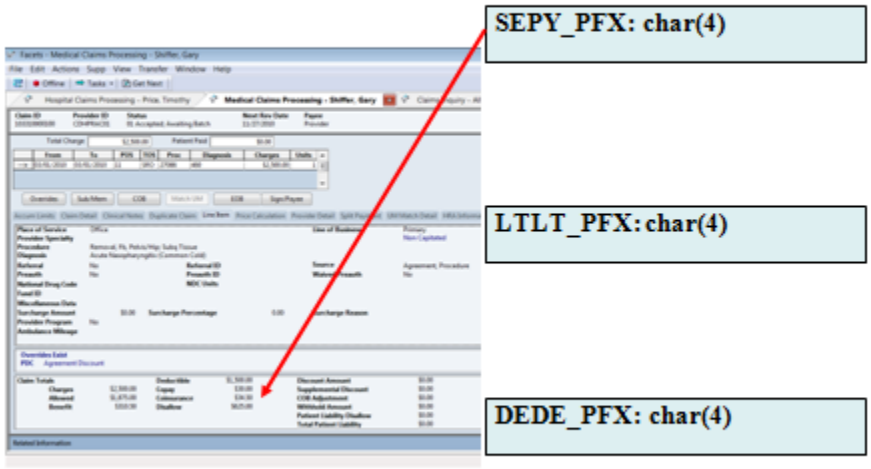
Medical Claim Line Item – CMC_CDML_CL_LINE



Type	Meaning
SEPY_PFX	This identifies the service payment row used in adjudication.
LTLT_PFX	This identifies the limit row used in adjudication.
DEDE_PFX	This identifies the deductible row used in adjudication.

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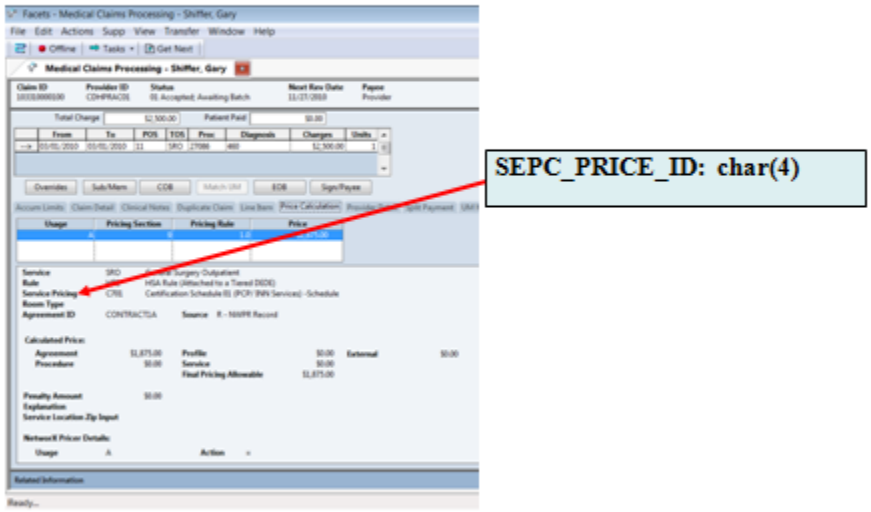
Medical Claim Line Item – CMC_CDML_CL_LINE



Type	Meaning
SEPC_PRICE_ID	This identifies the service's pricing table row used in adjudication of the line item.

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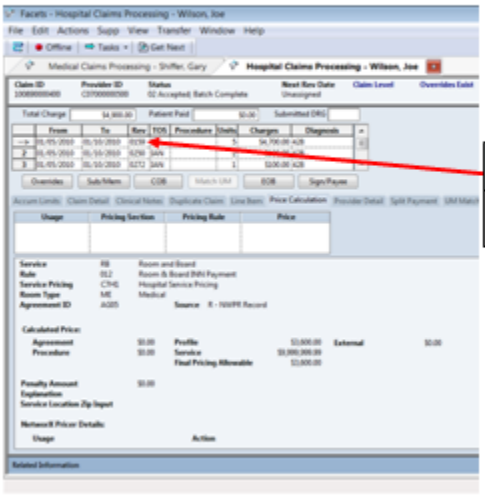
Medical Claim Line Item – CMC_CDML_CL_LINE



Type	Meaning
RCRC_ID	This indicates the industry standard revenue code found on hospital claims that identifies the type of service performed.

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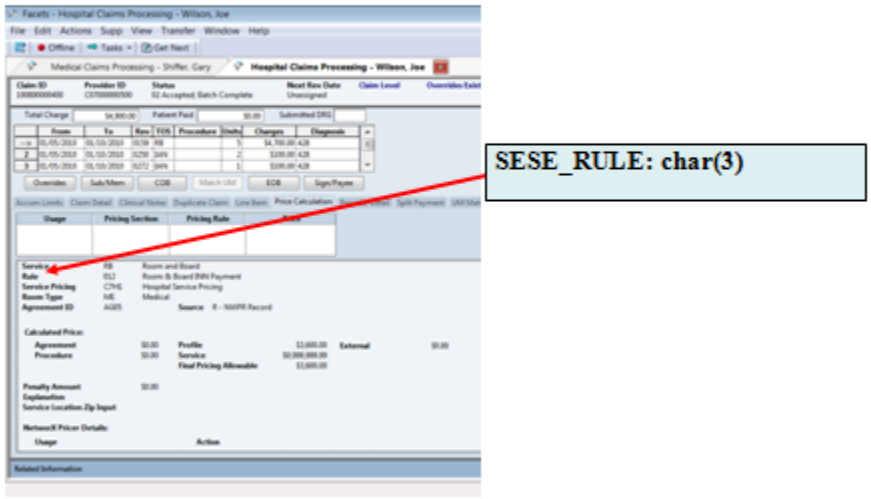
Medical Claim Line Item – CMC_CDML_CL_LINE



Type	Meaning
SESE_RULE	This indicates the calculation rule for the corresponding type of service (TOS) on the line item.

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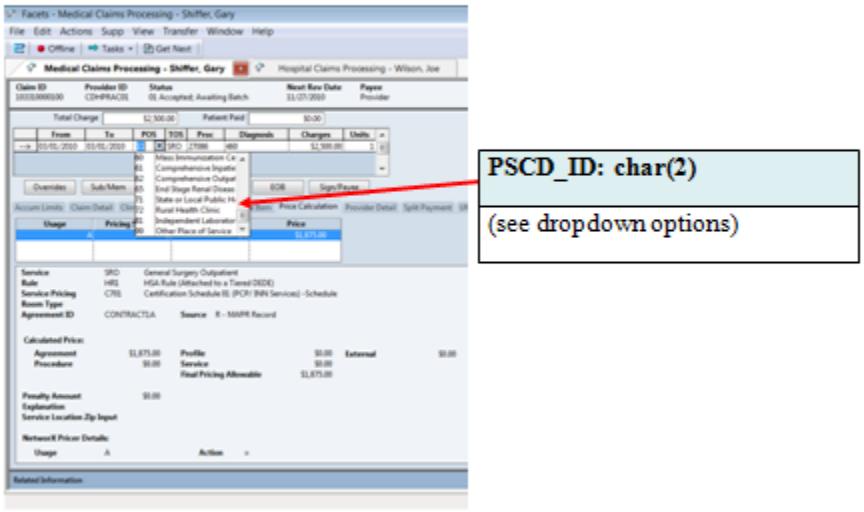
Medical Claim Line Item – CMC_CDML_CL_LINE



Type	Meaning
PSCD_ID	The user selects the 2-character (CMS compliant) code indicating the place of service for this line item. Options include: Facets 5.x contains 45 codes in all.

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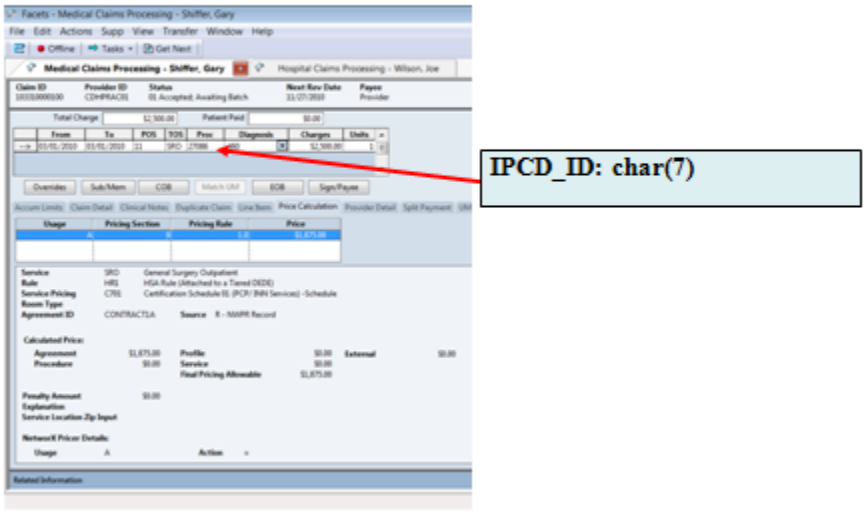
Medical Claim Line Item – CMC_CDML_CL_LINE



Type	Meaning
IPCD_ID	This Procedure Code indicates the standardized coding of the service performed (CPT-4, ICD-9/10, or HCPCS).

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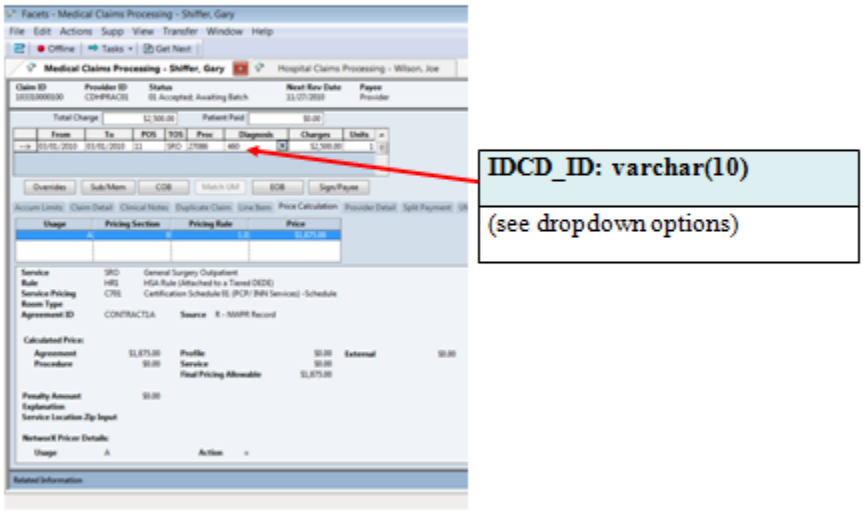
Medical Claim Line Item – CMC_CDML_CL_LINE



Type	Meaning
IDCD_ID	The user selects the diagnosis code that classifies the condition, illness, or injury being treated.

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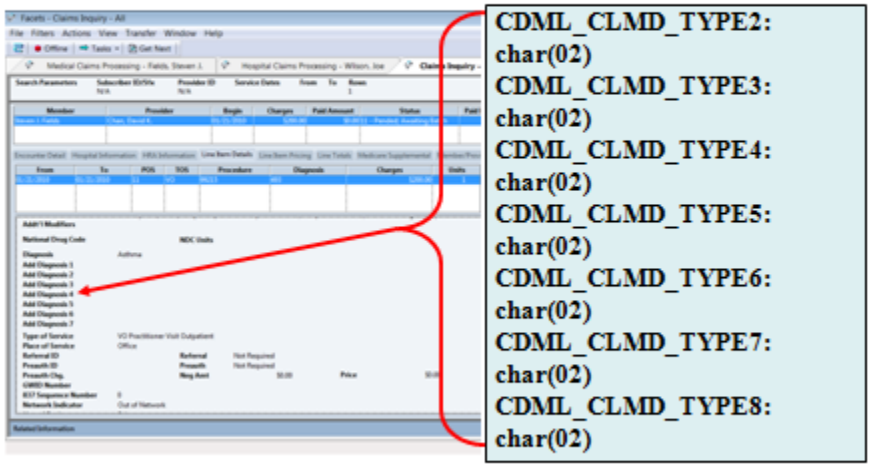
Medical Claim Line Item – CMC_CDML_CL_LINE



The 26 pointers that correspond to additional line item diagnoses include the following values:

- AD – Admitting
- 2 - 18
- E1 - E3
- R1 - R3

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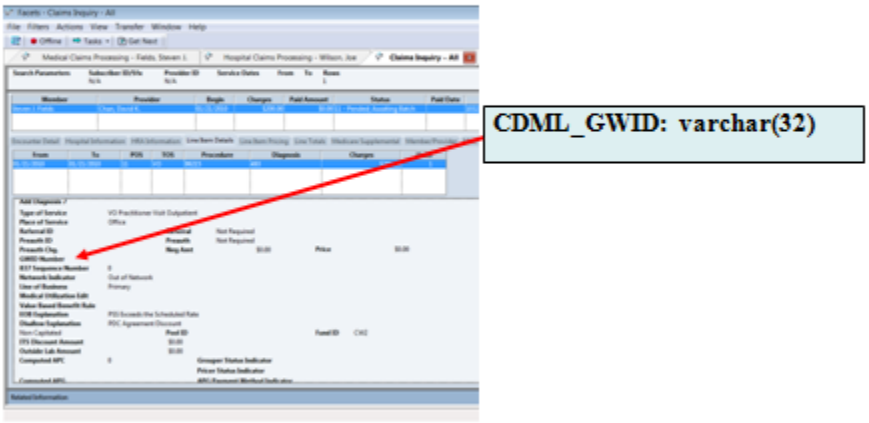
Medical Claim Line Item – CMC_CDML_CL_LINE



Type	Meaning
CDML_GWID	This indicates the HIPAA Gateway GWID Number of the medical claim line item. It only works for EDI files that go through the TriZetto HIPAA Gateway.

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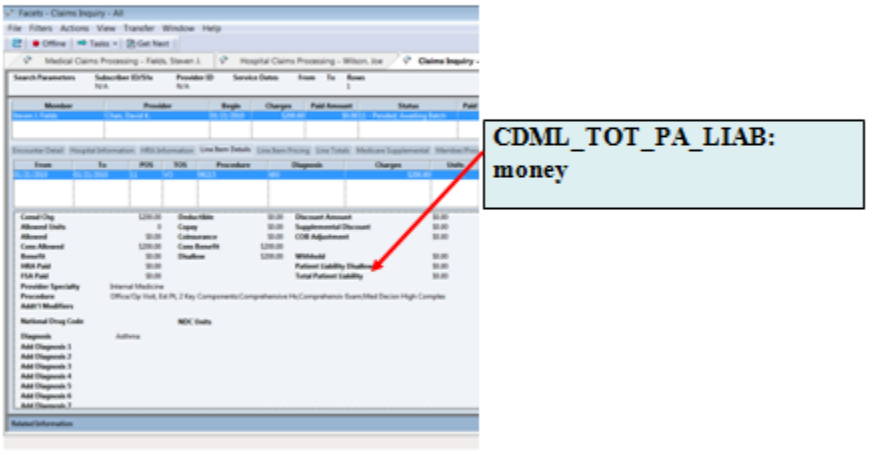
Medical Claim Line Item – CMC_CDML_CL_LINE



Type	Meaning
CDML_TOT_PA_LIAB	This represents the Total Medical Patient Liability amount including deductibles, co-pay, coinsurance, and disallow amounts reimbursable for HRA processing coming from the extension.

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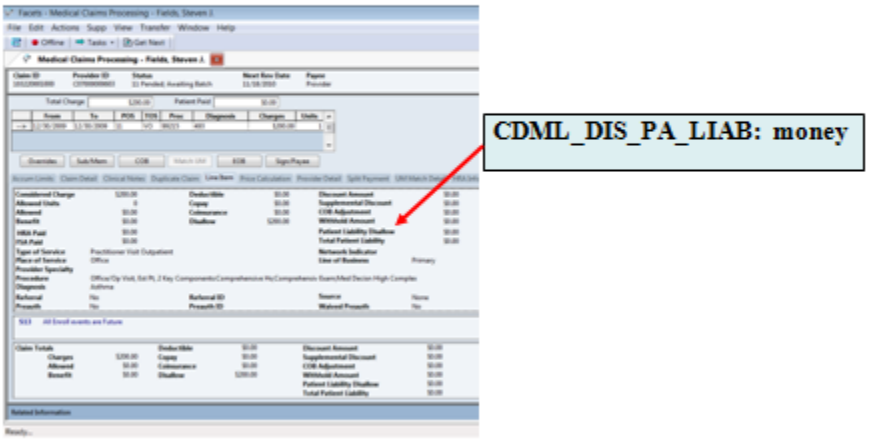
Medical Claim Line Item – CMC_CDML_CL_LINE



Type	Meaning
CDML_DIS_PA_LIAB	This represents the Medical Patient Liability Disallow amount eligible for HRA reimbursement coming from the extension.

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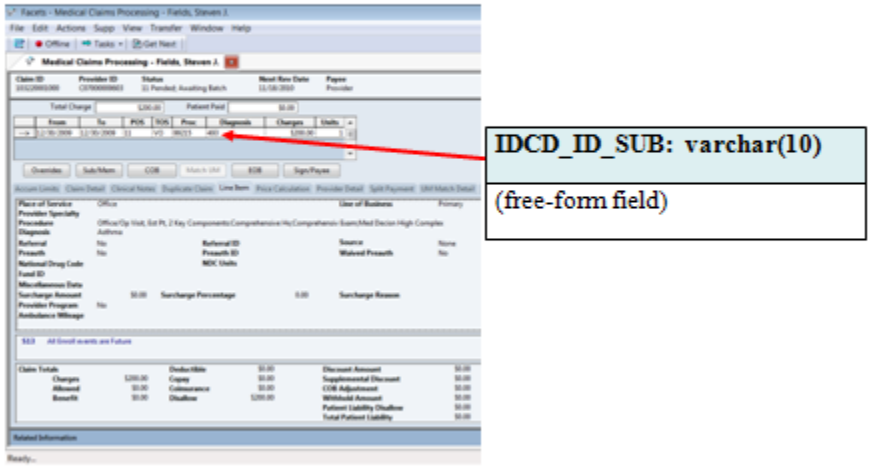
Medical Claim Line Item – CMC_CDML_CL_LINE



Type	Meaning
IDCD_ID_SUB	This indicates the submitted diagnosis on the claim line.

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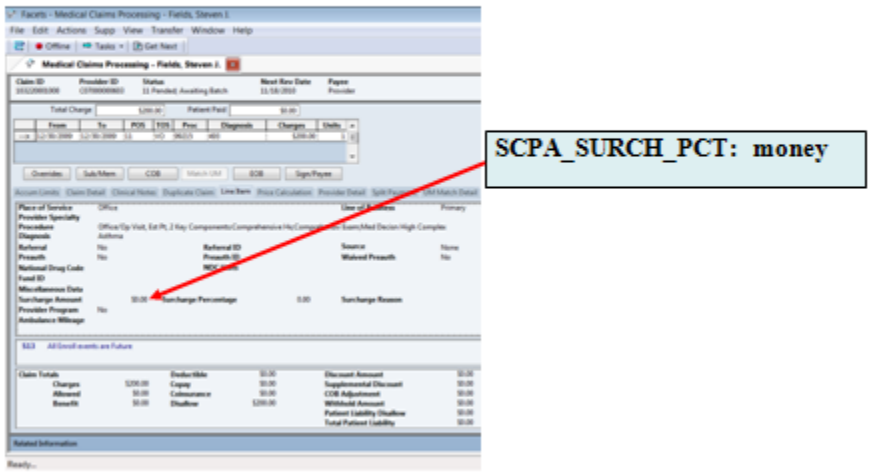
Claims Tables - CMC_CDSD_SUPP_DATA

Claims Tables - CMC_CDSD_SUPP_DATA



This table stores line level data supplemental to the main claim table.

Line Level Data	Meaning
SCPA_SURCH_PCT	This identifies the Surcharge Amount copied from the **Surcharge Percentage** field on **CMC_SCPA_SURC** table.

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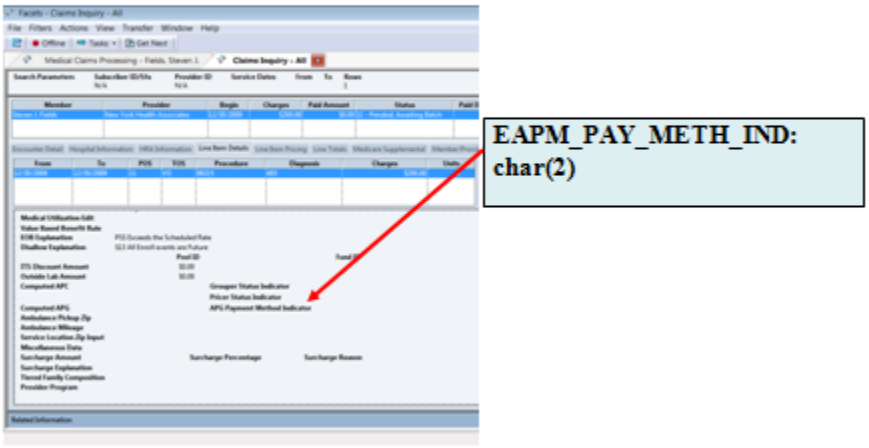
Claims Tables - CMC_CDSD_SUPP_DATA



Type	Meaning
EAPM_PAY_METH_IND	This identifies the EAPG (Enhanced Ambulatory Payment) Method indicators.

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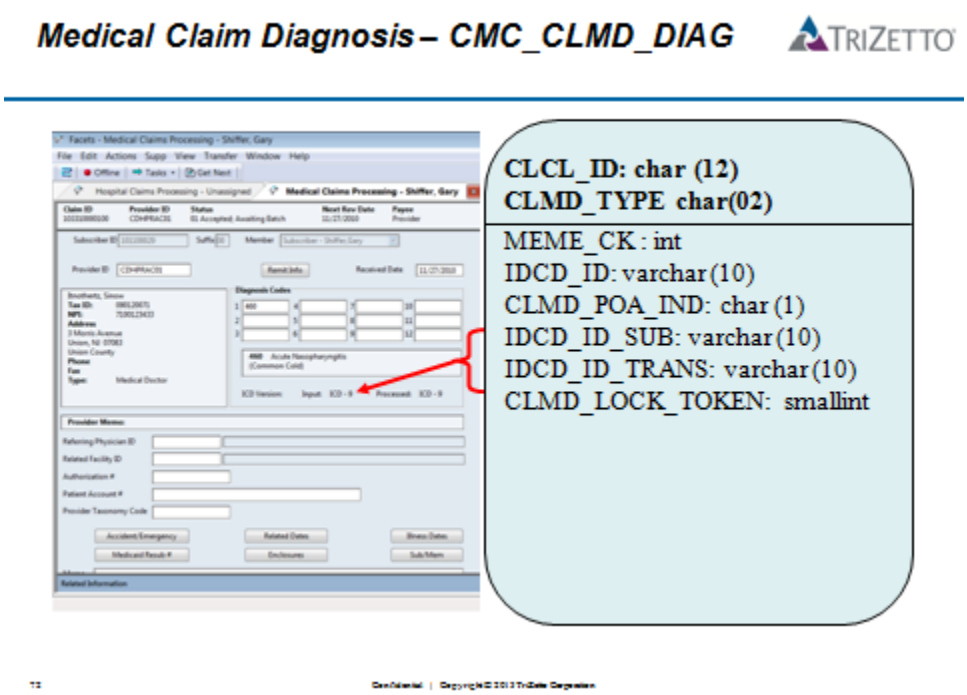
Medical Claim Diagnosis – CMC_CLMD_DIAG



A function found on the main diagnosis table (**CLMD**) supports 5010 processing. The claims application contains the capability to track the version of ICD codes submitted (IDCD_ID_SUB) on the claim, as well as the translated code (IDCD_ID_TRANS), to ensure compliance with 5010 regulations.

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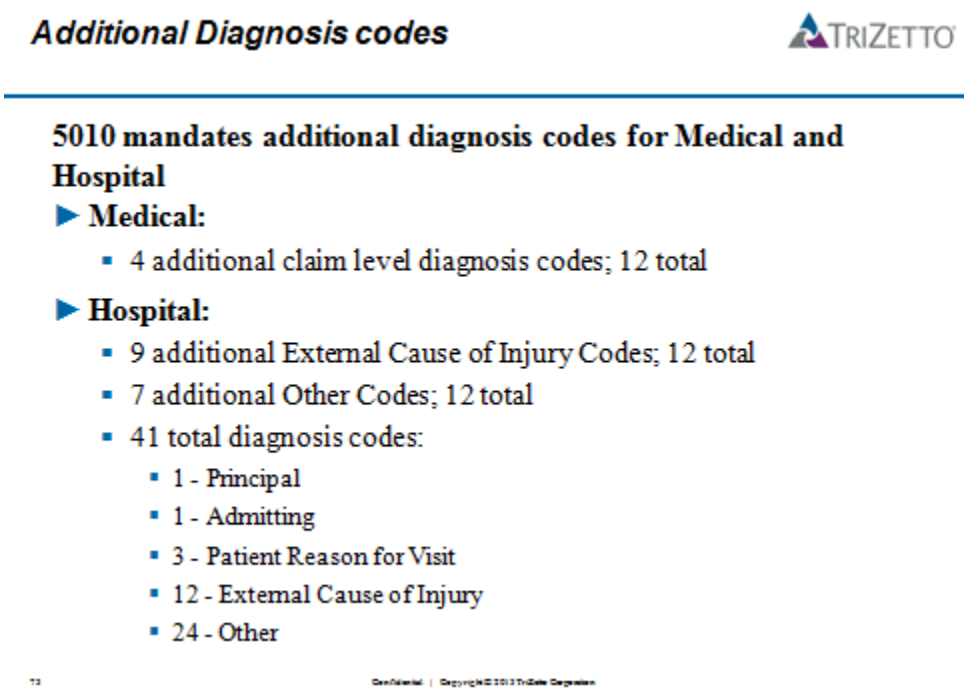
Additional Diagnosis codes



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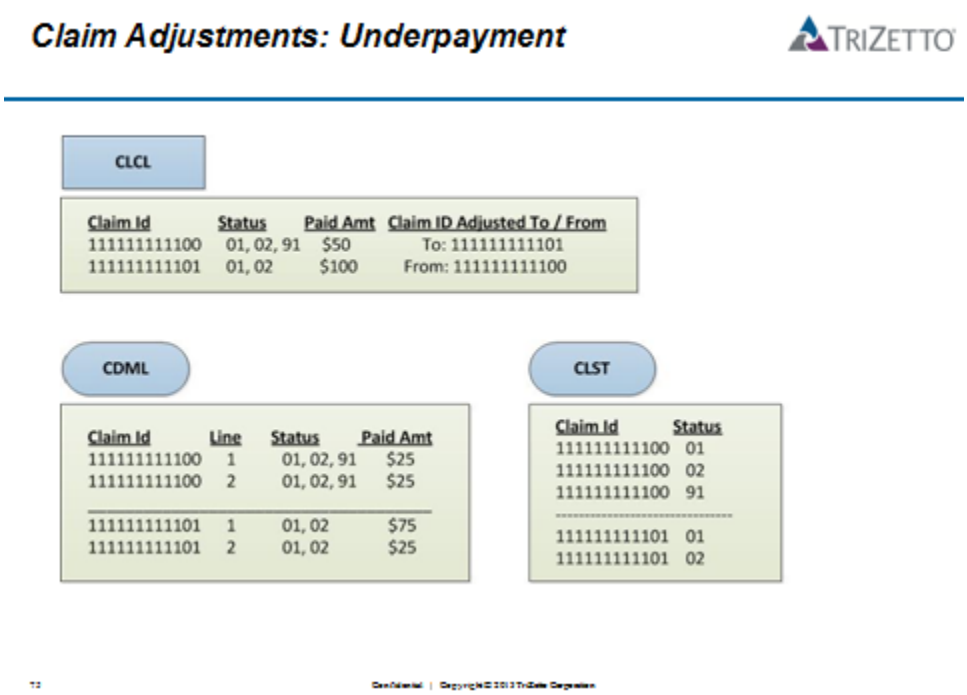
Claim Adjustments: Underpayment



Facets contains two types of adjustments; overpayment and underpayment. This slide represents the underpayment adjustment. The first line displays the original claim that paid $50. Due to some change or review, Facets determined that not enough money was paid for the services under this claim. On the **CDML** table, each service line paid $25, but the first service line needed to pay $75.

To correct the payment, Facets created a new claim using the first ten digits of the original claim and a suffix of 01. Facets put the original claim in a status 91 - Adjusted Processed Claim. The new or adjusted claim needed to go through the adjudication and payment processes. When it reached the payment batch, Facets created a row on the **CMC_CLCK_CLM_CHECK** table, and read the original claim to determine how much of the claim already paid. Facets put this in the **CLCK_PRIOR_PD** column and deducted it from the amount of the adjusted claim. Facets paid anything left over.

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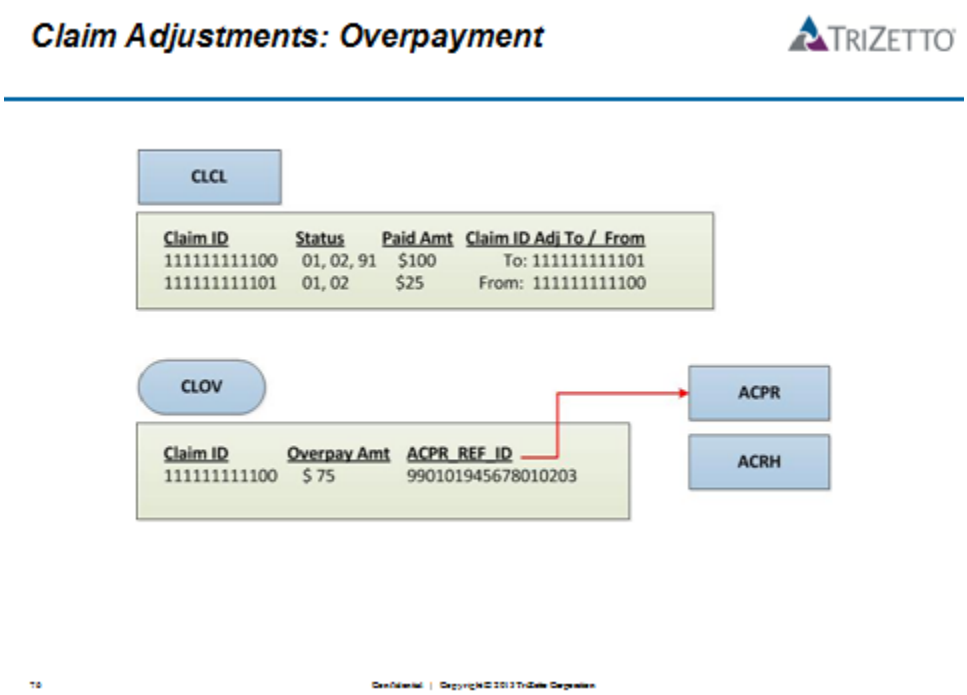
Claim Adjustments: Overpayment



In the overpaid claim, the same process takes place with one exception, the adjusted claim is less than the original claim.

This creates a row on the **CMC_CLOV_OVERPAY** table, which holds a reference to the **Accounting** table, **CMC_ACPR_PYMT_RED**. This table tracks the reduction of the overpayment on subsequent claims. The **CMC_ACRH_RED_HIST** table holds the amount deducted from each claim until the overpayment gets satisfied.

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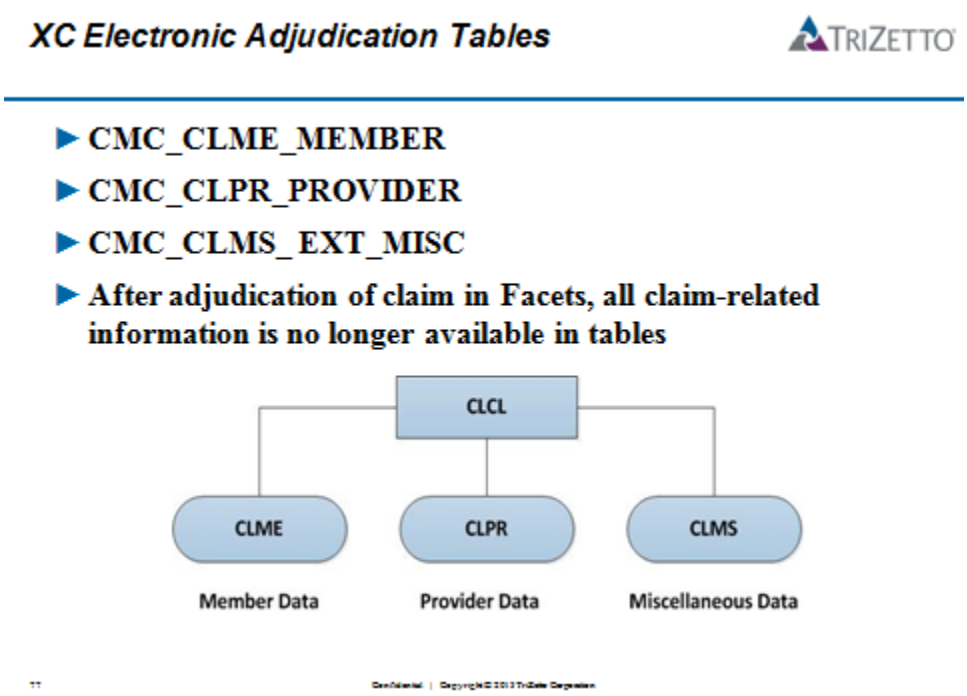
XC Electronic Adjudication Tables



Electronic Adjudication Table	Meaning
CMC_CLME_MEMBER	This stores all submitted data for the subscriber/member associated with the claim.
CMC_CLPR_PROVIDER	This stores submitted data for all providers associated with a claim.
CMC_CLMS_ EXT_MISC	This contains miscellaneous information relating to the claim.

After Facets adjudicates a claim, all claim-related information no longer displays in these tables.

The XC database, a separate database from the production database, holds external claims, such as 837s. This database mainly comprises of only the claims tables with a few exceptions, such as the tables defined above. The electronic adjudication process reads this database for status 16 - Claim Pended Following Batch Processing Entry only. All claims in a status 15 – Pended with Error remain on the XC database until corrected. All claims that successfully adjudicate indicate a status of 01 – Claim Accepted; Awaiting Batch and get moved from the XC database into the production database. The moved claims acquire a status of 99 – Closed on the XC database. A parameter in the Electronic Adjudication batch deletes all the status 99 claims from XC after all claims moved successfully to production.

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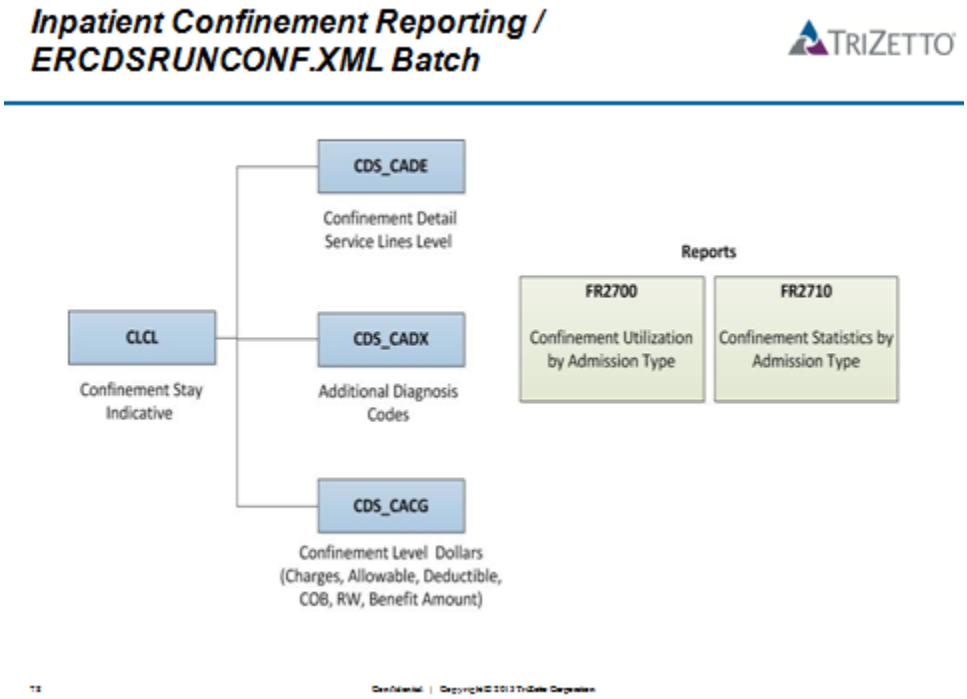
Inpatient Confinement Reporting



Facets uses the Inpatient Confinement Reporting / ERCDSRUNCONF.XML batch to analyze Cost and Utilization figures associated with inpatient hospitalizations.

Facets uses these figures to understand the admitting patterns of providers, the prevalence and cost of certain diseases, and the types of cases treated.

Facets populates the four tables above by the Inpatient Confinement batch, ErCdsRunConf.xml. This batch gathers information from hospital claims in the production database and breaks down the information into categories per diagnosis code. For a specific diagnosis code, the result determines the average cost for that specific treatment. The two built in reports Facets contains include FR2700 and FR2710. They display the information in different ways.

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Objective Summary

You are now able to:

- Discuss the important columns of the major tables
- Explain the relationship of the columns to the other tables and domains as they pertain to the Facets processes
- Explain the common elements among the tables

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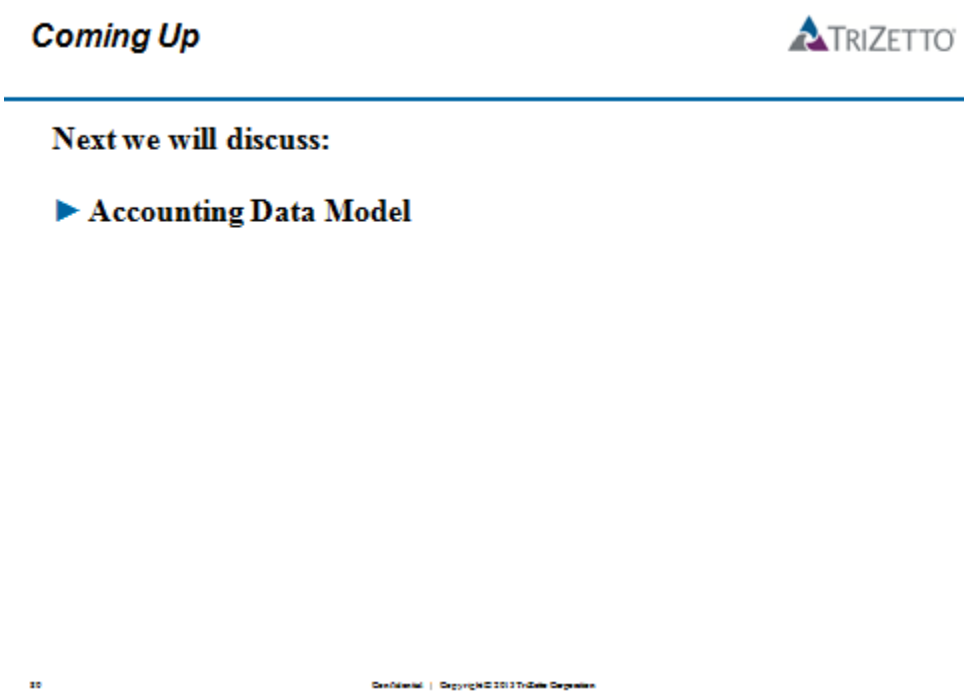
Coming Up



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