Variable Components

Facets 5.0
Participant Guide

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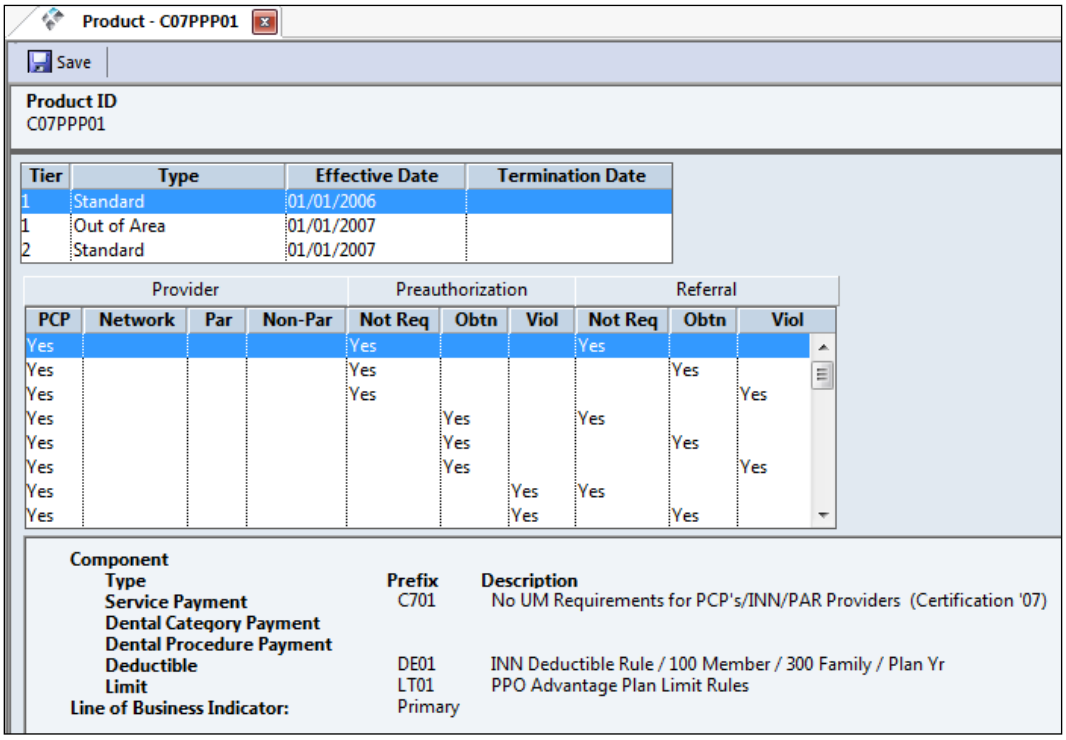
Variable Components Section

This section of a product stores three component types: Service Payment, Deductibles, and Limits. They are labeled ‘variable,’ because the prefixes used to identify these components can change based on the service provider, service location (in-area vs. out-of-area), and if UM requirements are satisfied. During claims processing, Facets will select one of these scenarios to determine how to pay benefits for each service on the claim using the identified Service Payment, Deductible, and Limit prefixes. Health plans can also assign tier levels to providers and, therefore, be able to designate different levels of payment based on the tiers.



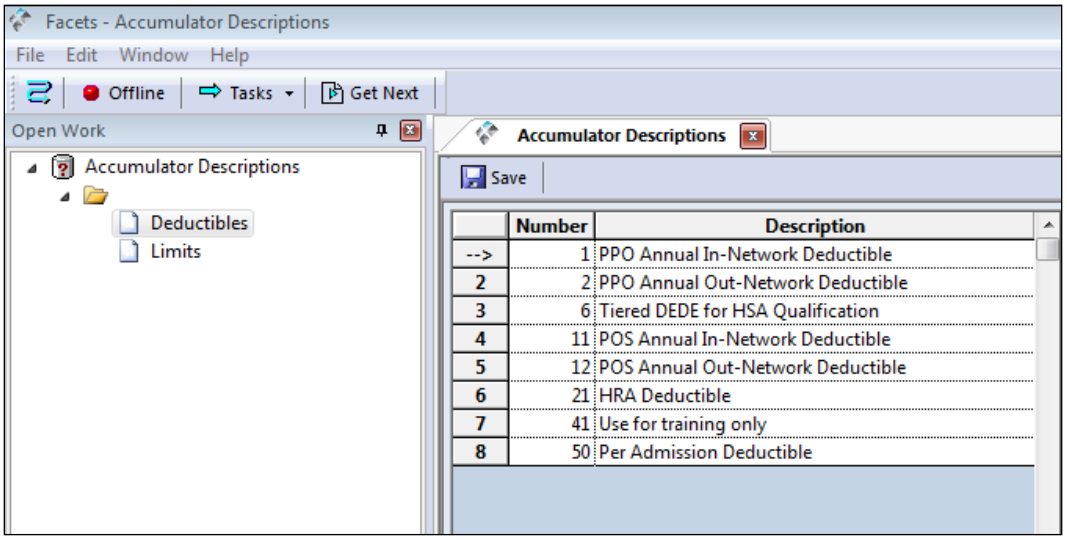
Accumulator Descriptions Application

This application allows the user to globally define accumulator (bucket) numbers and their descriptions for potential deductible and limit benefit rules. The user may view the descriptions along with the accumulator bucket numbers in the Claims Processing, Family Accumulator, and Member Accumulator applications.

The accumulators listed here will be used when creating deductibles and limits for a plan and product. Take 'order' into consideration when numbering the limit accumulators, as Facets will read the accumulators in order during processing. As a configuration suggestion: list stoploss limits first, followed by annual limits, then lifetime limits.

Deductibles and Limits sections

These sections allow users to enter an accumulator bucket number and description for an accumulator.



	Number	Description
-->	1	PPO Annual In-Network Deductible
2	2	PPO Annual Out-Network Deductible
3	6	Tiered DEDE for HSA Qualification
4	11	POS Annual In-Network Deductible
5	12	POS Annual Out-Network Deductible
6	21	HRA Deductible
7	41	Use for training only
8	50	Per Admission Deductible

Adding Accumulator Description

Step	Adding an Accumulator Description
1	Open the ***Deductibles*** or ***Limits*** section, select **Add** from the **Edit** menu (**Alt+E+A**) or place the cursor in the last row and select the **ENTER** key.
2	Type the number of the accumulator bucket and a description.
3	Select **Save** from the **File** menu (**Ctrl+S**), or select the **Save** button to save the changes/additions made.

Once the descriptions and bucket numbers have been added here, the bucket number(s) and descriptions will display when creating Limit and Deductible Rules.

The entries made in this table will not overlay descriptions already existing in the Limit and Deductible Rules applications. However, when querying the accumulators (in Claims or in the Member and/or Family Accumulator applications), the description entered here will display on the screen.

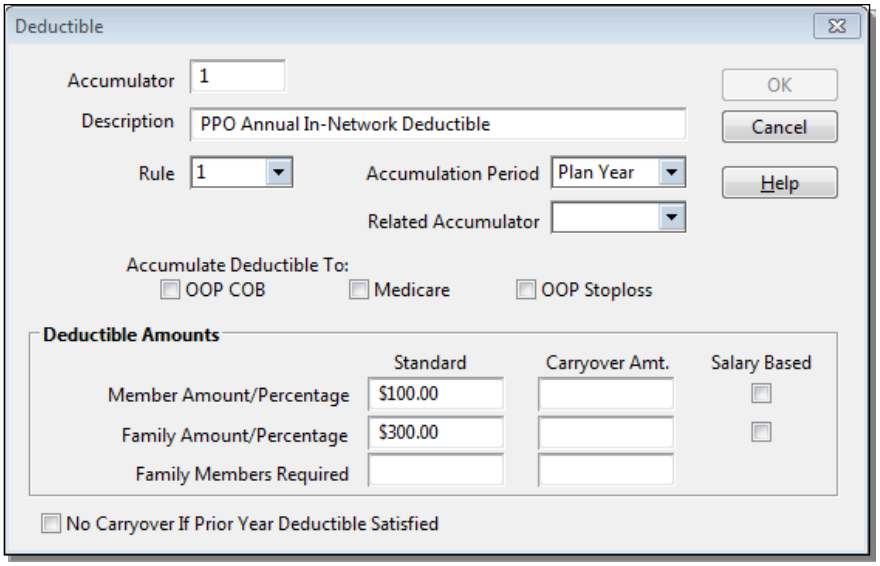
Deductible Rules Application (DEDE)

The Deductible Rules application is a variable component of the product used to store the type of rule and dollar amount to be paid by the member before payment begins by the health plan. This may be based on a plan year, calendar year, or lifetime basis. This record is used in Claims and Claims/UM combined products, but is not used in Claims Pre-Pricing products.

Indicative Section

This section allows a user to view and enter the deductible rules for all claims processed under plans using this product prefix.

The following image is an example of an in-network deductible; however, deductibles may be the same for in-network and out-of-network.



Field		Description
Fields denoted with an * are required.		
Accumulator		This number corresponds to the deductible accumulator on the Service Rule record.
Description		User-defined description of this deductible.
Rule		Select a type of deductible from the drop-down box (see below for further information).
Accumulator Period		Period of time this deductible will accumulate; Plan Year, Calendar Year, or Lifetime.
Related		This field allows a user to relate accumulators together for simultaneous updates. For example,

Field		Description
Accumulator		a user may relate an annual physical therapy (PT) deductible to an out-patient therapy lifetime deductible. Amounts applied to the PT deductible also apply to the lifetime out-patient deductible.
Accumulate Deductible To OOP COB		Check this box if this deductible rule should be included in (accumulate to) the member's out-of-pocket accumulators.
Accumulate Deductible To Medicare		Check this box if this deductible rule should be included in (accumulate to) the member's out-of-pocket Medicare.
Accumulate Deductible To OOP Stoploss		Check this box if this deductible rule should be included in (accumulate to) the member's out-of-pocket stoploss.
Deductible Amounts: Member Amount/Percentage Standard		Enter the standard member deductible. If the **Salary Based** checkbox is checked, this value is the percentage of the subscriber's salary. If this checkbox is not selected, the value is the dollar amount of the deductible. **Note**: The word, "Percentage" or "Amount", whichever applies, will appear in the text-out area below the grid.
Deductible Amounts: Member Amount/Percentage Carryover Amt.		Enter the dollar amount of the member deductible carryover.
Deductible Amounts: Salary Based		Check this box to indicate that the member's deductible amount is based on a percentage of the subscriber's salary. If the box is checked, the value in the **Member Amount/Percentage Standard** field is the percentage. If the box is not checked, the value in the **Member Amount/Percentage** field is the deductible amount. **Note**: This check-box is available only if "Rule 1, Per Person, with or without family aggregate" is selected. **Note**:
Deductible Amounts:		Enter the standard family deductible. If the **Salary Based** checkbox is checked, this value is

Field		Description
Family Amount/Percentage Standard		the percentage of the subscriber's salary. If the checkbox is not selected, this value is the dollar amount of the deductible. **Note**: The word, "Percentage" or "Amount", whichever applies, will appear in the text-out area below the grid.
Deductible Amounts: Family Amount/ Percent Carryover Amt.		Enter the dollar amount of the family deductible carryover.
Deductible Amounts: Salary Based		Check this box to indicate the family's deductible amount is based on a percentage of the subscriber's salary.
Deductible Amounts: Family Members Required Standard		If a deductible rule is based on a number of persons meeting their deductible, enter that number. **Note**: If the "Per Person with number of persons" or "Per Person with family aggregate and number of persons" was selected in the **Rule** field, users must enter the number of persons in this field.
Deductible Amounts: Family Members Required Carryover Amt.		Enter the number of persons who must meet their deductible amount in order for the family deductible to be satisfied. The number entered in this field must be less than or equal to the number specified in the "Family Members Required Standard" field.
No Carryover If Prior Year Deductible Satisfied		Check this box to bypass any carryover to the current year when the prior year's deductible has been satisfied. If the prior year's deductible has not been satisfied, the standard carryover provision will apply. **Note**: This option applies only to Member level Accumulators. If Family Accumulators are used, standard carryover provisions apply whether or not this option is selected.

Limit Rules Application (LTLT)

The Limit Rules application is a variable component of the product used to store various rules that apply to different limits included in a subscriber/member's benefit package. This record is used to define each benefit limitation or stoploss (out-of-pocket maximum) applicable to a health plan. Each limit rule may be applicable to selected benefit types based on amounts paid or allowed, or based on the number of services paid/applied during a plan year period or during the member's lifetime.

A limit is a dollar amount or number of counters that, once reached, will result in no further benefit reimbursement. Limits may be at the member-level or the family-level, and may be based on a dollar amount or a number of counters.

This variable component is required in Claims and Claims/UM combined products, but is not required or used in Claims Pre-pricing products. It is used in UM products if 'limit checking' is enabled in the Administrative Rules application.

Note: The Limit Rules application supports the auditing functionality.

Indicative Section

This section displays the plan limit rules for all claims processed under plans using this product prefix. This information is entered using the ***Limit Accumulator*** dialog box by selecting **Add**…**Section** from the **Edit** menu **(Alt+E+A+S).** The grid at the top of the screen displays the accumulator identification number and description. When a row in this grid is selected, detailed information about that limit is found in the section tabs.

Indicative Section Tab

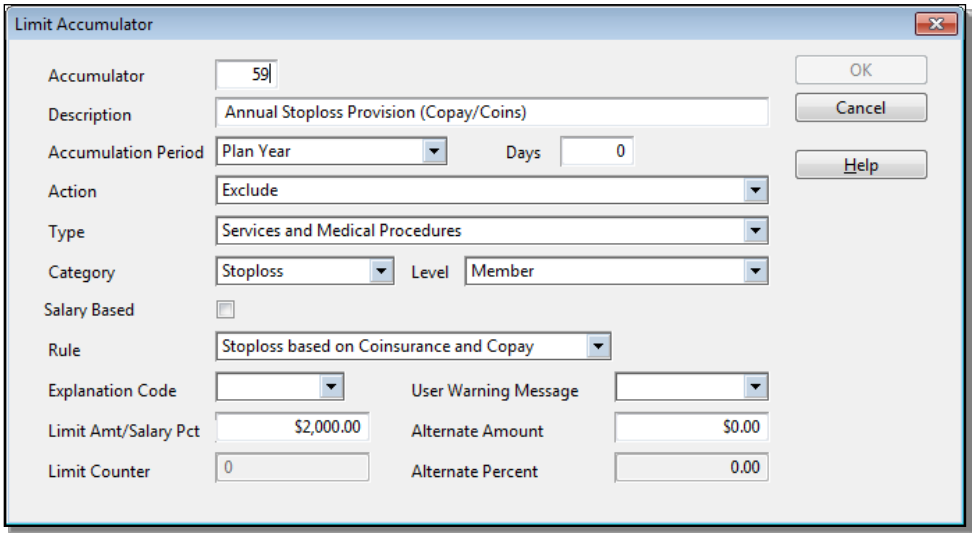
This section tab displays detailed information about the limit rule selected in the grid in the Indicative section.

In this application, the user may also establish waiting period exclusions at the product level for both claims and UM processing, as well as exclusions for a list of services, diagnoses, and procedures not covered for all members who enroll in the product; this is set-up in the ***Services***, ***Related Diagnoses,*** and ***Procedures*** section tabs. The "Exclusionary Period Credit" field in the Subscriber/Family and Enrollment applications allows the user to credit individual subscribers with a specified number of days if they have already accrued exclusionary period days.

Note: When numbering the limit accumulators, the order should be taken into consideration, as Facets will read the accumulators in order during processing. List stop-loss limits first, followed by annual limits, then lifetime limits.

Adding Limit Rules

Step		Adding Limit Rules Procedures
Steps denoted with an * are required.		
1		To add a new Limit Rule select **Add**…**Section** from the **Edit** menu (**Alt+E+A+S**) to access the ***Limit Accumulator*** dialog box.



Step	Adding Limit Rules Procedures (continued)
2	Tab through the fields to enter the appropriate information, and then select **OK**.
3	Enter necessary Service IDs, Diagnosis, and Procedure codes in the section tabs.
4	Select **Save** from the **File** menu (**Ctrl+S**) when finished.

Field		Description
Fields denoted with an * are required.		
Accumulator	*	Enter the accumulator row number (up to 9,999) for the member or family to which this Limit will accumulate.
Description		Enter a user-defined description of the accumulator (plan year, calendar year, or lifetime).
Accumulation Period	*	Select whether the limit accumulation occurs on a P – Plan Year, C – Calendar Year, L – Lifetime or E – Exclusionary Period Days basis. The default

Field		Description
		is “Plan Year.” To establish an exclusionary period limit, users must select E - Exclusionary Period Days in this field and E - Exclusionary Days in the “Category” field. **Note**: If the date on the claim spans an exclusionary period set-up on this record, the claim will need to be split.
Days		Enter the number of days in the exclusionary period.
Action	*	Select a value to relate an Action to one or more Types. The value identifies whether services, diagnoses, procedures, or categories should be included or excluded when accumulating toward the limit. Valid values include: • A – Include All (select this value to include all available Types for a Limit Rule). • E – Accumulate to Stoploss but Do Not Apply (select this value to store dollar amounts up to a predetermined threshold but the value will not be applied to a selected Type for a Limit Rule). • I – Include (select this value to include a selected Type for a Limit Rule). • X – Exclude (select this value to exclude a selected Type for a Limit Rule).
Action(continued)		**Note**: Using the **Action** field and **Type** field (below) allows users to establish a single limit for a combination of different types of claim elements. These two fields work together to product specific combinations of components to be applied to rule accumulators. If an Action other than “Include All” is selected, a value is required in the **Type** field. If no Action is selected, an error message is generated. (This field works in conjunction with the **Type** field. See below for information on processing logic).
Type	*	Required if any action other than A – Include All is selected. Select a value to relate a Type to an Action. **Note:** This field works in conjunction with the **Action** field above.
Category	*	Select the type of data to be accumulated.

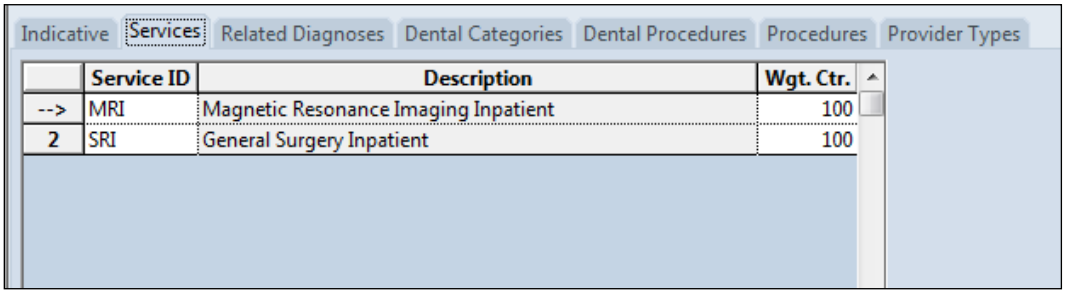
Field		Description
		The default is “Limit”. If creating “Paid” or “Encounter unit” types of limit rules (P or E in the “Rule” field), L - Limit must be selected in this field. If E - Exclusionary Period Days was selected in the “Accumulation Period field, E – Exclusionary Period must be selected in this field. **Note**: If E - Exclusionary Period Days was selected in the “Accumulation Period field and E – Exclusionary Period was selected in the “**Category**” field, at least one entry must be made in the Services, Related Diagnoses and/or Procedures section tabs. **Note**: When “Salary Based” is selected, the “**Category**” field cannot be set to “L-Limit.”
Level	*	Select a value identifying the level at which the limit or stoploss is processed—the default value is “Member.” To select the option of establishing a family maximum based on a number of members, enter the limit amount in the **Limit Amount** field, and enter the number of members in the **Alternate Amount** field.
Salary Based		Select this box if the stoploss amount is based on the Subscriber’s salary. If this box is checked, the value in the “**Limit Amt./Salary Pct.**” field is the percentage. If this box is not checked, the value in the “**Limit Amt./Salary Pct.**” field is the limit dollar amount. **Note**: “Salary Based” is available only for values other than L – Limit in the “Category” field. **Note**: Facets uses the salary (found in the Subscriber/Family application), whose effective date matches the service date on the claim, to calculate deductible and stoploss. If a claim line item is received and a salary-based deductible is indicated but no corresponding salary is found in the Subscriber/Family application, Salary section with an indicator of “**Yes**” in the “**OOP**” field, an error message displays stating: “Salary Based Deductible. Member Does Not Have an Annual Salary.”
Rule	*	Enter how the Accumulator will be calculated (see below for further information).
Explanation Code		Select the appropriate Explanation Code.
User Warning		Select a user-defined warning message to be

Field		Description
Message		linked to this limit rule. Whenever this limit rule is met or exceeded, the message displays for every applicable line item on every claim.
Limit Amt./Salary Pct.		Enter the maximum accumulation: either the dollar amount or the percentage of the salary, to indicate that the rule can be established for a particular amount or a percentage. If the "**Salary Based**" box is checked, the value is the percentage of the subscriber's salary. If the "**Salary Based**" box is not checked, the value is the maximum dollar amount. **Note**: Once the limits are defined, the **Record Information** area of the Indicative section displays the percentage or amount.
Alternate Amount		Enter the yearly carryover or reinstatement amount.
Limit Counter		Enter the maximum counter amount for the accumulation.
Alternate Percent		Enter percentage amount of carry-over or yearly reinstatement.

Each limit rule is specific to included or excluded Service IDs or Diagnosis Codes, as selected in the **Type** field. When selecting one of these, also select the appropriate section tab to identify all of the codes to be included or excluded.

Services Section Tab

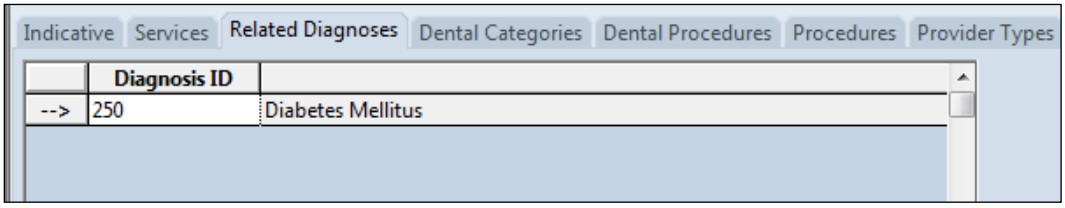
Use this section tab to specify those service codes to be included or excluded in this Limit Accumulator rule. During claims processing, if the service(s) entered match the ones indicated here, those services will be applied or excluded from the limit per the selection made in the **Action and Type** fields in the ***Limit Accumulator*** dialog box.



Field		Description
Fields denoted with an * are required.		
Service ID	*	From the drop-down field select a TOS code.
Description		Select the **TAB** key after entering a Service ID, this will auto-fill this field.
Wgt. Ctr.		Enter the weight or percentage at which the corresponding Service ID codes will be multiplied in order to determine the correct number to be applied.

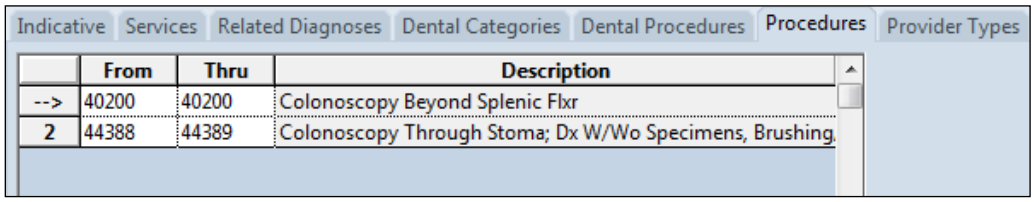
Related Diagnoses Section Tab

Use this section tab to specify the diagnosis codes to be included or excluded in this Limit Accumulator rule. During claims processing, if the diagnosis code(s) entered matches the ones indicated here, the services related will be applied or excluded from the limit per the selection made in the **Action and Type** fields in the ***Limit Accumulator*** dialog box.



Procedures Section Tab

Accommodate medical procedures that are to be included or excluded in the exclusionary period. Any procedures entered in this section tab can also be applied to other types of limit rules in addition to the exclusionary period.

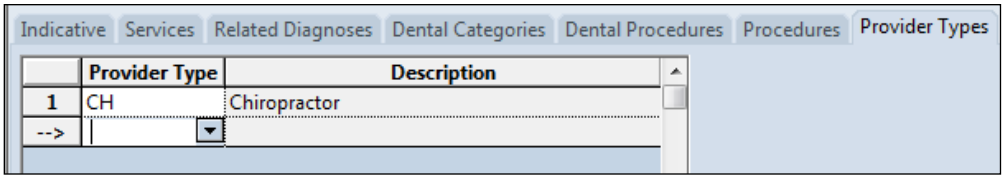


Field		Description
Fields denoted with an * are required.		
Procedure Code From	*	Enter the beginning code for this procedure code range to be included or excluded during limit processing and accumulations.
Procedure Code Thru		Enter the ending code for this procedure code range to be included or excluded during limit processing & accumulations.

Provider Types Section Tab

Users may select “Provider Type” (in the **Type** field of the ***Limit Accumulator*** dialog box) as part of the Plan Limit inclusion criteria for both facility and professional claims. This section tab allows users to select a specific Provider Type applicable to the Limit Rule. This allows for the following Limit Rule scenarios:

- Listed Provider Types included
- Listed Provider Types excluded
- Accumulate Listed Provider types to Stoploss but do not apply



Field		Description
Fields denoted with an * are required.		
Provider Type		Select a user-defined Provider or Facility Type for this Limit Rule.

Product Variable Components

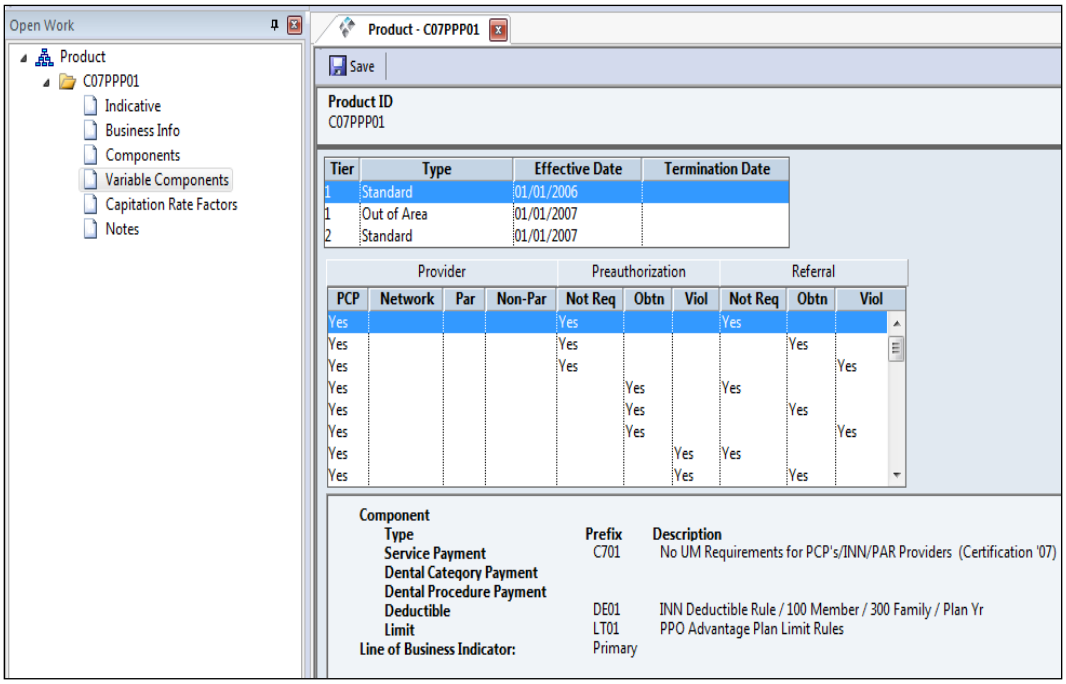
Product Application

Variable Components Section

This section of a product stores three component types: Service Payment, Deductibles, and Limits. They are labeled ‘variable,’ because the prefixes used to identify these components can change based on who performed the service, where the service was performed (in-area vs. out-of-area), and if UM requirements were satisfied. During claims processing, Facets will select one of these scenarios to determine how to pay benefits for each service on the claim using the identified Service Payment, Deductible, and Limit prefixes. MCOs can also assign tier levels to providers and, therefore, be able to designate different levels of payment based on the tiers.

To use out-of-area Types, establish zip code ranges using the In Area Zip Codes application found in the Medical Plan application group, and then link to the member’s product.

When a claim or UM review is processed or pre-priced, Facets uses the servicing provider’s primary address zip code to determine in-area or out-of-area records.

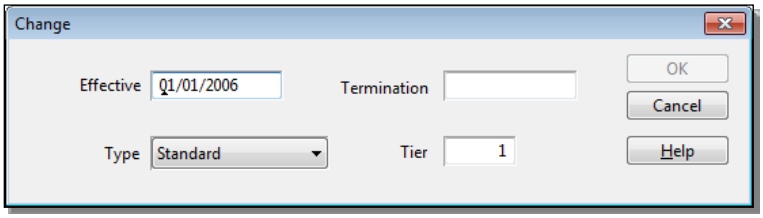


The ***Variable Components*** section has seven Types, each containing the same 36-scenarios of how a service can be rendered to a member:

Type		Description
Fields denoted with an * are required.		
Standard		General row used to set-up the initial 36 scenarios of how a service can be rendered.
Out of Area		If the In Area Zip Codes (ZCIA) application component type is added to a product and the servicing provider's primary address does not fall in the zip code range identified in this component, Facets will refer to this row for payment rules during claims processing.
Accident in Area		If the services rendered on a claim are due to an accident of some sort and the provider is considered "in-area" with respect to the plan, Facets will refer to this row for payment rules during claims processing.
Accident Out of Area		If the services rendered on a claim are due to an accident and the provider is considered to be "out-of-area" with respect to the plan, Facets will refer to this row for payment rules during claims processing.
Emergency in Area		If the services on a claim are identified as an 'emergency' and the provider is considered to be "in-area" with respect to the plan, Facets will refer to this row for payment rules during claims processing.
Emergency Out of Area		If the services on a claim are identified as an 'emergency' and the provider is considered to be "out-of-area" with respect to the plan, Facets will refer to this row for payment rules during claims processing.
Opt-out		"Opt Out" pertains to the Assigned Risk Module only. It is used to designate the Variable Component type of the product to 'opt out' of POS processing. This option identifies members who choose not to participate in the highest benefit level offering.

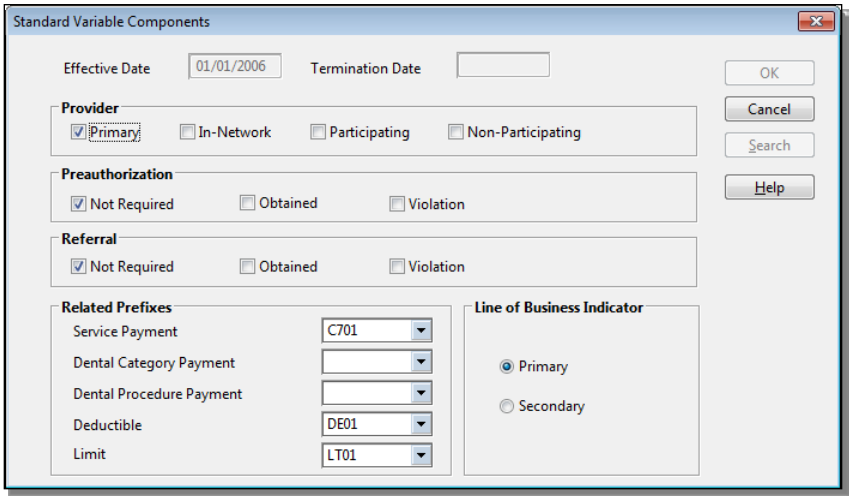
Maintaining Variable Components

Step	Maintaining Variable Components Procedures
1	Verify the ***Variable Components*** section screen displays, as shown above. If it is not displayed, select the **F12** function key once, use the **up- or-down arrow *keys*** to select the ***Variable Components*** section, and select the **ENTER** key.
2	To add information in this section, select **Add**…**Section** from the **Edit** menu (**Alt+E+A+S**) to display an ***Add*** dialog box, enter Effective and Termination Dates. You can establish different Effective and Termination Dates for each Variable Components section.
3	Enter the "**Type**" and "**Tier**" fields.
4	Select **OK** to accept the entry.



Field		Description
Fields denoted with an * are required.		
Effective	*	Enter the date this Variable Component row became effective.
Termination		If no longer used, enter the date this Product Variable Component row was terminated.
Type	*	Select the Variable Component Type.
Tier	*	Enter a number to assign a different level of payment to a provider (tier). Facets uses this tier to determine which Variable Component row to apply during adjudication, matching the tier with the tier on the Network Set (NWST); there must be a match between the tier number in this field and the tier on the NWST. **Note**: Since the Tier indicator is established on the NWST application, users must link tiered providers by network.

Step	Maintaining Variable Components Procedures (continued)
5	Select **Add**…**Subsection** from the **Edit** menu (**Alt+E+A+B**) to display the ***Variable Components*** dialog box. The name of the dialog box will depend on the selection made in the "**Type**" field. Use this dialog box to enter the 36-different situations that a service may be rendered, as well as the appropriate Service Payment, Deductible, and Limit prefixes to be used for each situation.
6	Use the **TAB** key to move from field-to-field. Use the **SPACEBAR** to select and deselect entries in the checkbox and fields. Use the **Alt** + **up**-and-**down arrow keys** to select options from the dropdown fields and to select or deselect the **Line of Business Indicator** radio buttons.



Field		Description
Fields denoted with an * are required.		
Effective/Terminate Date	*	Enter the date-range in which the listed situations and variable components are valid, for the indicated "Type".
Provider Checkboxes	*	Identifies the type of provider who rendered the service. Choices are: Primary (PCP), In-Network, Participating and Non-Participating.
Pre-authorization Checkboxes	*	Identifies the pre-authorization status of the rendered service. Choices are: Not Required, Obtained (it was required), and Violation (it was required and it was not obtained).
Referral Checkboxes	*	Identifies the referral status of the rendered

Field		Description
		service. Choices are: Not Required, Obtained (it was required), and Violation (it was required and not obtained).
Related Prefixes	*	Five drop-down menu fields used to indicate the variable components used when a service is rendered according to the selected checkboxes for Provider, Pre-authorization and Referral.
Line of Business Indicator	*	Identifies the Line of Business to be used when a service is rendered according to the selected checkboxes for Provider, Pre-authorization, and Referral. “Secondary” relates to the Alternate Line of Business ID indicated in the Business Info section of the product.

The **Edit** menu bar offers the following additional options.

- **Insert** - use to add an additional row in-between existing rows in the bottom grid.
- **Validation** - use to display a ***Variable Component Validation*** dialog box used to verify the 36-different scenarios that may be set-up for a given Type.
- **Add Generation** - use to duplicate existing scenario rows and related prefixes for a specific Type. Facets requires an Effective date be entered via a dialog box. The date will be used to identify when the new or duplicate “Type” should become active and when the old “Type” should be terminated. After creating the duplicate Type, you can then make the necessary changes to the scenario rows and related prefixes.

Note: A Variable Component row cannot have overlapping Effective and Termination Dates between different generations. If this is the case when creating a generation through the **Add** or **Add Generation** options Facets will display an Error message stating overlapping dates exist.

The following are the valid Variable Components for each “Type:”

Primary Care Provider	In Network Provider	Participating Provider	Non-Participating Provider
Pre-auth./Referral	Pre-auth./Referral	Pre-auth./Referral	Pre-auth./Referral
Not Required/Not Required	Not Required/Not Required	Not Required/Not Required	Not Required/Not Required
Not Required/Obtained	Not Required/ Obtained	Not Required/ Obtained	Not Required/Obtained
Not Required/Violation	Not Required/ Violation	Not Required/ Violation	Not Required/Violation
Obtained/Not Required	Obtained/Not Required	Obtained/Not Required	Obtained/Not Required
Obtained/Obtained	Obtained/ Obtained	Obtained/ Obtained	Obtained/Obtained
Obtained/Violation	Obtained/ Violation	Obtained/ Violation	Obtained/Violation
Violation/Not Required	Violation/Not Required	Violation/Not Required	Violation/Not Required
Violation/Obtained	Violation/ Obtained	Violation/ Obtained	Violation/Obtained
Violation/Violation	Violation/ Violation	Violation/ Violation	Violation/Violation