Application Support

5.0
Participant Guide

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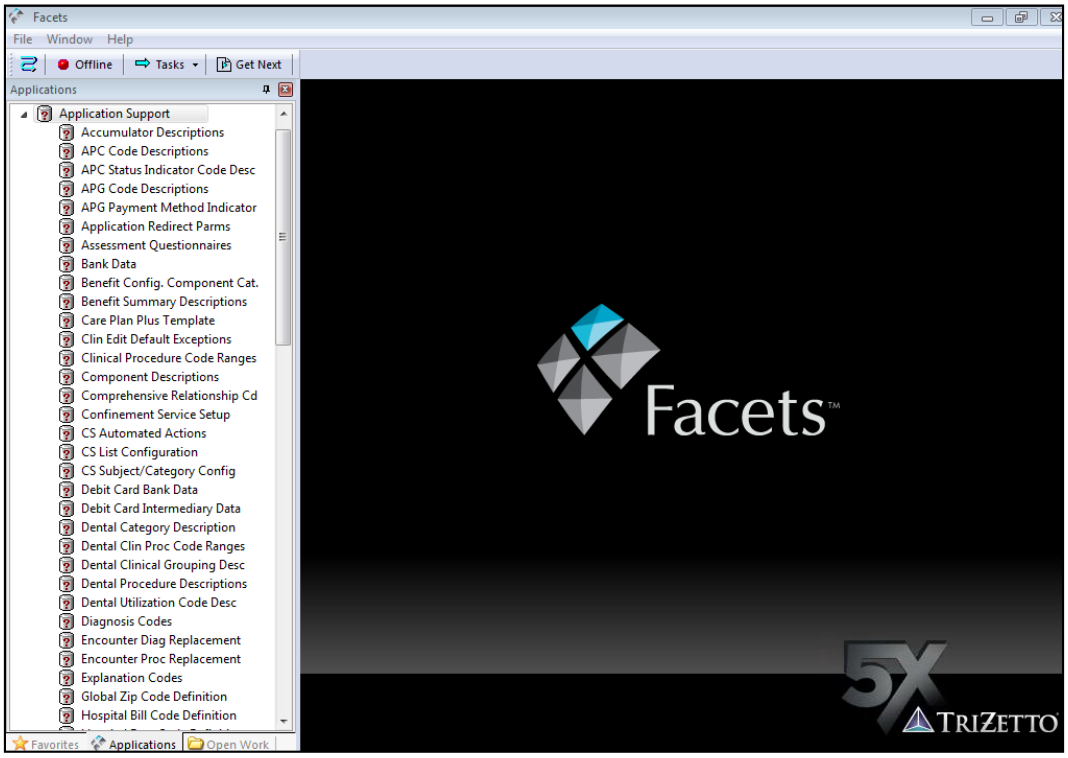
Application Support

Application Support Application Group

From the **Applications** tab, select the Application Support application group. This application group serves as a central library for all codes and standard information entered into Facets on a regular basis. Each application maintains a specific type of information that displays as field selections throughout Facets.



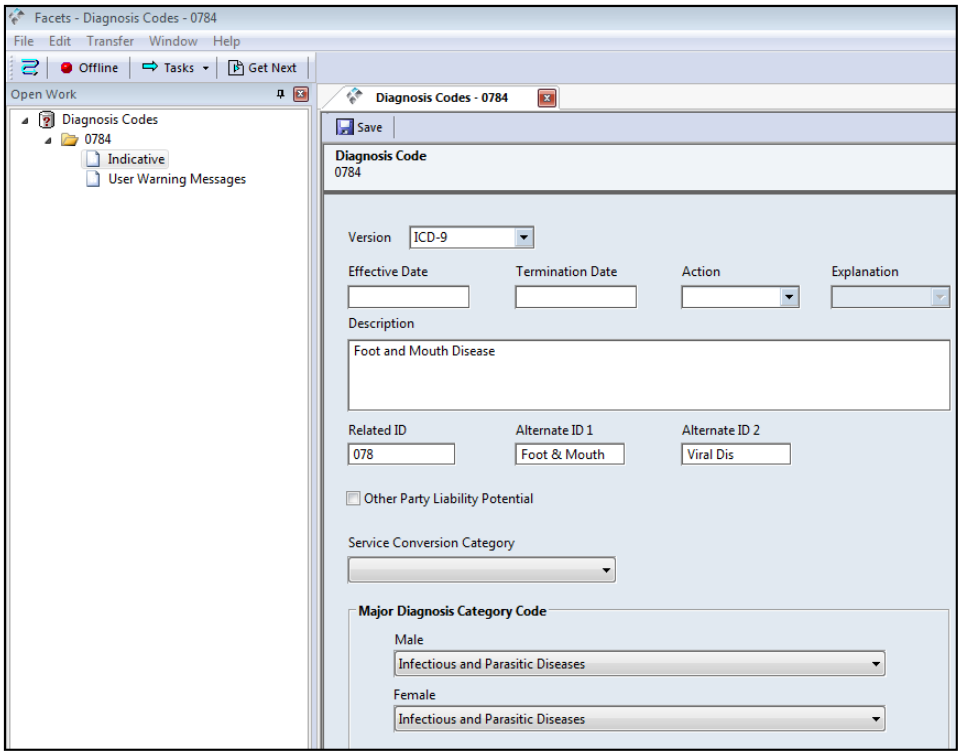
Diagnosis Codes Application

This application is used to view or edit existing diagnosis codes. TriZetto supplies the diagnosis code table; it is typically loaded into the Facets database automatically during the implementation process.

TriZetto supplies the diagnosis codes. Additional diagnosis codes may be entered as needed. Diagnosis code updates are provided on an annual basis.

Indicative Section

This section displays information pertaining to a diagnosis code.



Field		Description
Fields denoted with an * are required.		
Version	*	Select the type of diagnosis code. Valid values: I - ICD-9, T - ICD-10, and D – Non Standard.
Effective Date	*	The date this diagnosis code became effective.

Field		Description
Termination Date		The date this diagnosis code terminated.
Action		Select the action performed when a diagnosis code is submitted for a date of service outside the effective period of the code. This field is required if an effective date is entered. Options include: W – Warn, D – Deny and E – Error.
Explanation		Select the explanation code that generates when an ineffective diagnosis code is submitted and the Action is Deny. This field is required if Deny is selected in the **Action** field.
Description		Enter or change the user-defined diagnosis code description. TriZetto supplies industry standard diagnosis codes and their corresponding descriptions.
Related ID		Diagnosis codes can be grouped with other related diagnosis codes in a single category for searching, limit accumulation, and pre-existing conditions. This code represents the diagnosis category for a range of related conditions, illnesses, or injuries.
Alternate ID 1		Enter an alternate key word that can be used during the search routine to find the corresponding diagnosis code. For example, diagnosis code 250, “Diabetes Mellitus,” would probably have a form of the word, “Diabetes” as an Alternate Diagnosis ID.
Alternate ID 2		Enter an additional key word that can be used during a search to find the corresponding diagnosis code.
Other Party Liability Potential		Check this box to have Facets generate a warning message indicating that potential for other party liability exists for this diagnosis code. If this box is checked, a warning message will display when a claim or utilization management line item containing this diagnosis code is processed.
Non-Standard		Check the box to indicate whether the corresponding diagnosis code belongs to a

Field		Description
Code		non-standard coding system. This field is for informational purposes only and has no functionality. If left blank, the system assumes the code belongs to the ICD-10 coding scheme.
Service Conversion Category		This field categorizes the service based on diagnosis code. This is a user-defined field created in the User-Defined Codes application, Category = Plan Codes, Type = Service Conversion Category. After creating categories in the User-Defined Codes application, the user will see them as options in this field and make the appropriate selection.
Major Diagnosis Category Code/Male		Select a code to identify the corresponding Major Diagnosis Code as it pertains to males for this diagnosis code.
Major Diagnosis Category Code/Female		Select a code to identify the corresponding Major Diagnosis Code as it pertains to Females for this diagnosis code.

Diagnosis Codes Effective and Termination Dates

The **Effective** and **Termination Date** fields give the user the ability to warn, error, or deny line items when a diagnosis code is submitted prior to its effective date or after its termination date.

If there is more than one diagnosis code, only the primary diagnosis applies. These two fields apply to both claims and UM processing. These dates are not applied when diagnosis codes are entered on other applications.

If a claim with a diagnosis code outside the effective period is processed, Facets generates messages based on the action selected. An “Error” action generates an error message on the claims screen, “Warn” generates a warning message, and “Deny” disallows the line item. If a line item spans the diagnosis effective dates, an error message generates and the line item must be manually split. If the Benefit Calculation Date override is selected, Facets will use that date to compare against the effective and termination dates for the diagnosis code. When a line item is denied, the service/procedure conversion and service/revenue conversion routine will still occur. Clinical editing and the pricing routine will be bypassed if the line item is denied, but will occur if the action is “Warn”.

If a UM episode with a diagnosis code outside the effective period is processed, Facets will generate a warning message.

Note: It is recommended that customers add a User Warning Message to those diagnosis and procedure codes that overlap ICD-9 and ICD-10 (approximately 70 codes). This way, users may review claims and UM episodes processed with those affected codes.

User Warning Messages Section

Use this section to link date sensitive user warning messages to the diagnosis code. An unlimited number of messages can be in effect at any one time for each diagnosis code. After you save the record, the application will sort user message rows by Effective date.

The user warning message displays during claims and utilization management processing if the service date, begin date, or admit date of the record falls within the Effective and Termination dates of the user message(s) for the Diagnosis Code. If any date on the claim falls within the dates of the warning message, the warning message generates.

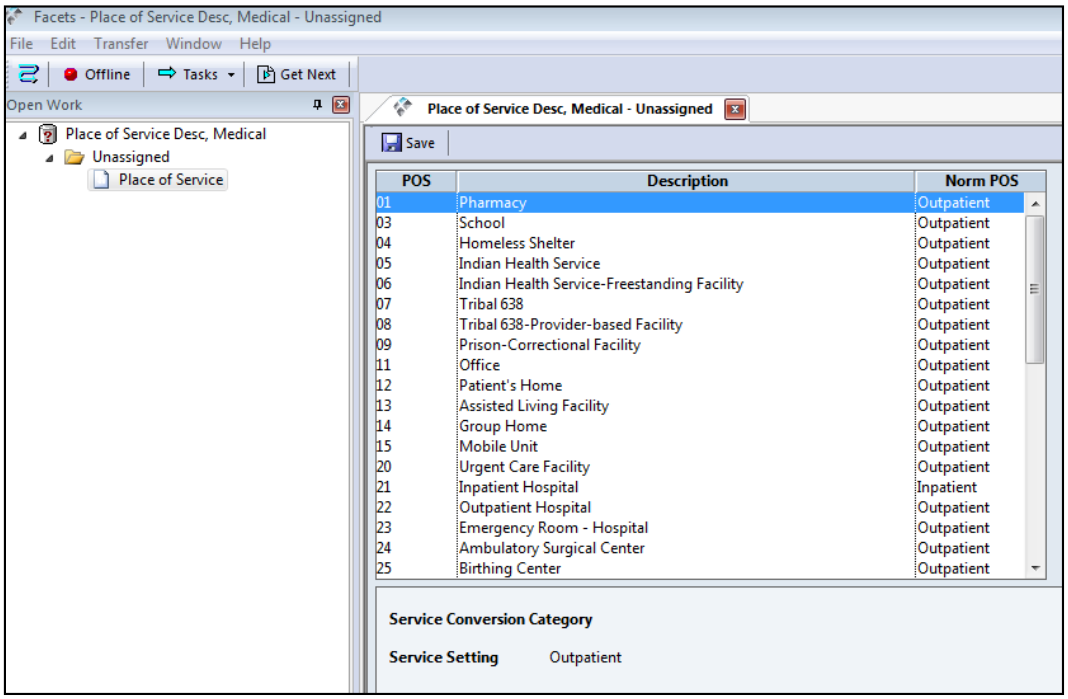
Place of Service Description, Medical Application

This application allows the user to equate a place of service (POS) with a user-defined code (e.g. “11” = Office Visit) and define whether this place of service is considered inpatient or outpatient (e.g. Normative Place of Service). A place of service that is considered inpatient refers to an individual who has been admitted to a hospital as a registered bed patient and is receiving services under the direction of a physician for at least 24 hours. A place of service that is considered outpatient refers to an individual who receives health care services without being admitted to a hospital.

When you open the application, all place of service codes and descriptions in Facets will automatically display. These values are TriZetto-supplied and based on the standardized listing of CMS-defined ‘places of service’.

Indicative Section

This section displays a grid listing the POS codes with a description for each one. This listing of codes is valid for the plans that use this set of information. Highlight a row in the grid to view details in the text-out area below the grid.



Field		Description
Fields denoted with an * are required.		
POS Code	*	Indicate a CMS-compliant code that identifies this place of service. TriZetto supplies a listing of industry standard place of service codes.
Normative POS	*	Select a code from the drop-down box, which identifies whether the normative setting for this place of service code is Inpatient (I), Outpatient (O), or Dental (D).
Service Conversion Category		This field categorizes the service based on place of service. This is a user-defined field created in the User-Defined Codes application, Category = Plan Codes, Type = Service Conversion Category. After creating categories in the User-Defined Codes application, the user will see them as options in this field and make the appropriate selection.
Service Setting		This is a user-defined field established in the User-Defined Codes application (Category = Plan Codes, Type = Service Setting) that describes the overall setting for this place of service. For example, the Place of Service code for a birthing center might be “M” for ‘maternity’. Therefore, procedures performed at this place of service would be considered ‘maternity’-related.
Description		May contain up to 70-alphanumeric characters. Enter a description for this place of service. TriZetto supplies a listing of industry standard descriptions.

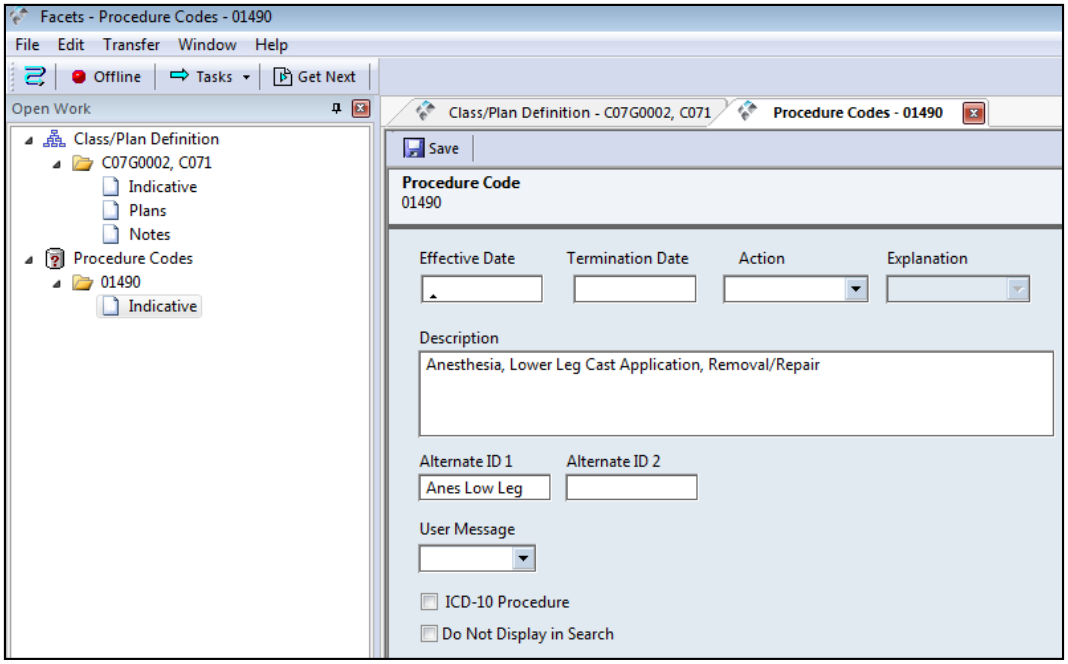
The Service Conversion Category is linked to the Provider and Diagnosis Code applications when converting the claim information to a service code. For example, users may want to point to separate service codes to vary the methods of payment when submitting procedures from a substance abuse counselor as opposed to a Primary Care Provider. The user will need to use another parameter to point to a different Service Code for payment purposes since there is no variance in the procedure based on the code itself.

Procedure Codes Application

This application allows the user to administer information about medical procedure codes in Facets. TriZetto supplies CPT-4 codes as well as HCPCS codes (CMS Common Procedural Coding System). These tables are usually loaded into Facets automatically during the implementation process. Updates are provided to customers in accordance with AMA and CMS updates.

Indicative Section

This section displays information for one procedure code.



Field		Description
Fields denoted with an * are required.		
Effective Date	*	The date this procedure code became effective.
Termination Date	*	The date this procedure code terminated.
Action		Select the action performed when a procedure code is submitted for a date of service outside the effective period of the code. This field is required if an effective date is entered. Options include W – Warn,

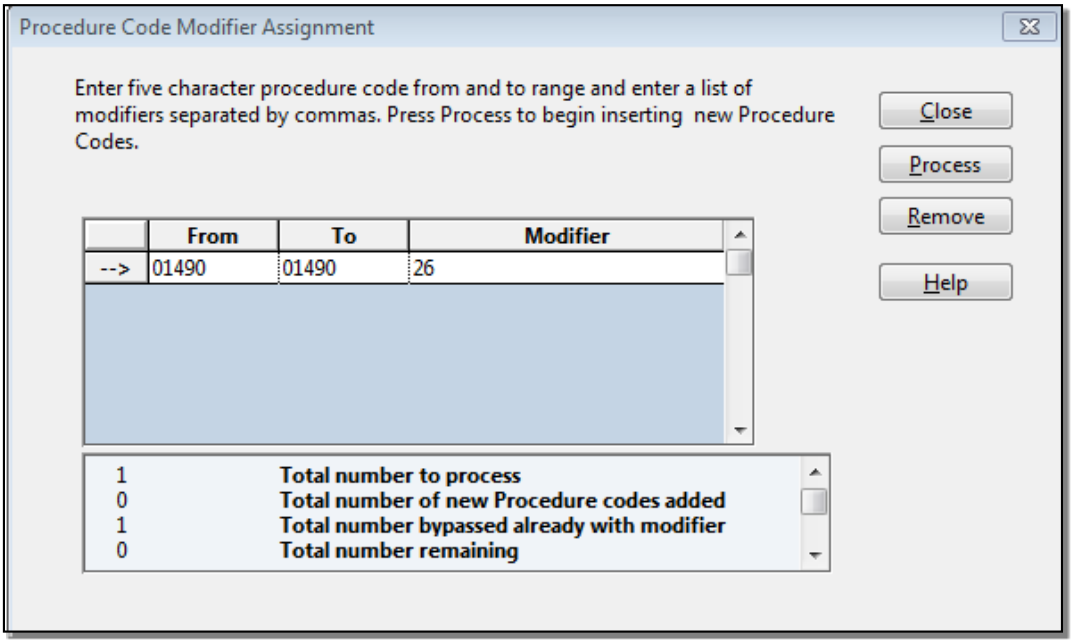
Field		Description
		D – Deny and E – Error.
Explanation		Select the explanation code that generates when an ineffective procedure code is submitted and the Action is Deny. This field is required if Deny is selected in the **Action** field.
Description		A user-defined description for this procedure code.
Alternate ID 1		An 'alternate' key word can be used during the search routine to find the procedure code. For example, 42826 Tonsillectomy could have an Alternate ID of "Tonsillectomy".
Alternate ID 2		An additional alternate keyword can be used during the search routine.
User Message		A 'User-Defined Warning Message' (previously created and set-up in the User Warning Message Description and the User Warning Messages application). This message displays during on-line processing. Facets matches the user's security level to that associated with the 'user message' to determine if the system requires the process to pend for additional review.
ICD-10 Procedure		Select this checkbox if this procedure code is an ICD-10 code.
Do Not Display in Search		Check this box if the procedure code should not display when searching for a procedure code.

While procedure codes generally have 5-positions, the user may generate rows in this procedure code table that contain the two-position modifier.

Assigning Modifiers to Procedure Codes

Step	Assigning Modifiers
1	Select **Generate Modifier Rows** from the **File** menu (**Alt+F+M**) to invoke the ***Procedure Code Modifier Assignment*** dialog box.
2	Enter the 5-character procedure code From and To range.
3	Enter the necessary modifiers to use for this range of procedure codes; separate them by commas.
4	Select **Save** from the **File** menu (**Ctrl+S**), or select the **Save** button.
5	Select **ENTER** at the end of a row to add an additional row in the grid.
6	To delete a row from the grid before processing, select the **Remove** button. At the ***Facets*** pop-up box, select the **Yes** button.
7	Select the **Process** button to begin inserting new procedure codes to this table when done entering the codes to be modified.
8	A pop-up box displays. Select **Yes** to proceed. Facets automatically generates new rows in the Procedure Codes application for the procedure codes with modifiers.

Facets displays messages in the grey, text-out area below the grid regarding the number of procedure codes the process will generate, the number of new procedure codes added, those codes that already have a modifier and will be bypassed, the total number of procedure codes remaining, and the percent (%) complete.



Step	Assigning Modifiers (continued)
9	Select the **Close** button to exit the ***Procedure Code Modifier Assignment*** dialog box.
10	Select **Save** from the **File** menu (**Ctrl+S**), or select the **Save** button.

Note: This application is unique in Facets since rows are added to the database when the user selects the **Process** button.

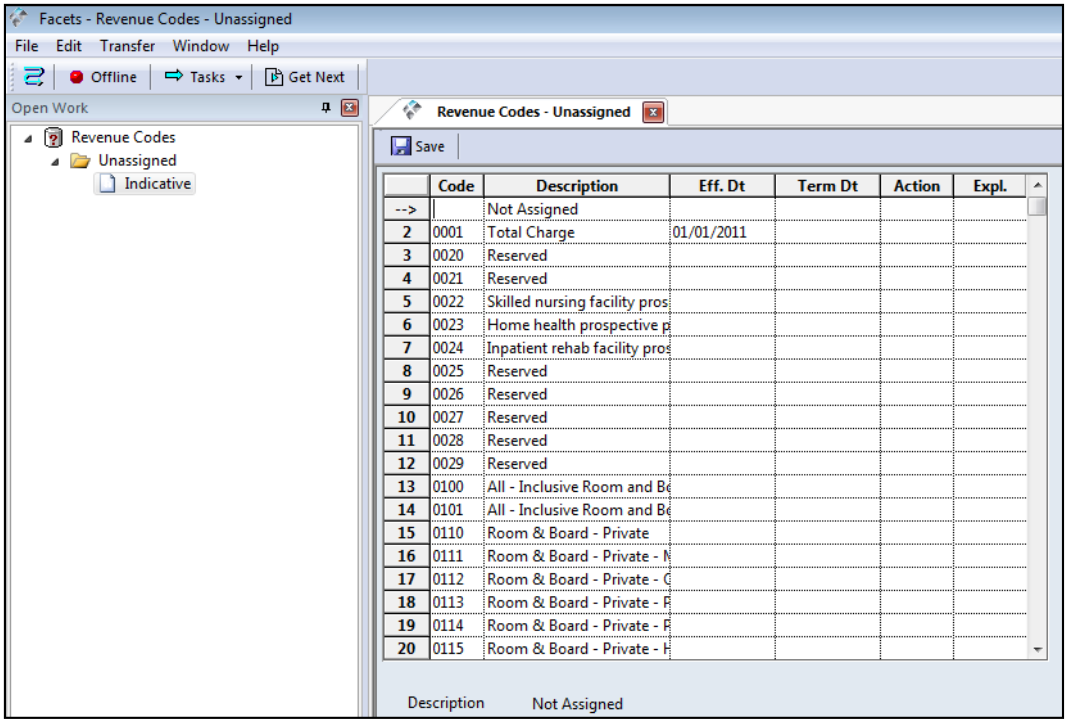
Note: The Procedure Codes application should hold all procedure codes, including ICD-9 codes used at the procedure code level. The ICD-9 procedure code application in Facets is solely used for the purpose of calculating length-of-stay criteria in Utilization Management Therefore, procedure codes listed in the ICD-9 application are not used anywhere else in Facets; they are not utilized in claims processing to validate the ICD-9 entries. Medical Claims Processing uses the Procedure Codes application to validate procedure codes.

Revenue Codes Application

TriZetto supplies this application, it is used to establish revenue codes and their descriptions used in claims and Utilization Management (UM) processing. Hospitals use revenue codes to bill for services rendered. When entered on the Hospital Claims Processing screen, they are converted to service codes already created in Facets.

Indicative Section

Facets displays all current revenue codes and descriptions in this section. The user may add or delete codes in the enterable grid.



User-Defined Codes Application

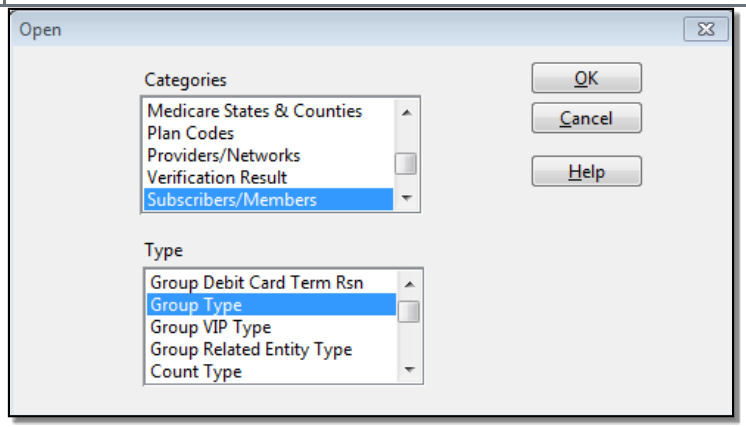
This application translates user-defined information into user-defined MCTR (Managed Care Translating) codes that are stored in the Facets database. The user is able to tailor codes to meet business needs. User-defined codes have no specific functionality; however, they are typically set-up for reporting purposes, routing, or channeling (in customer service).

Indicative Section

This section shows all of the user-defined codes linked to a selected category and type that are available throughout Facets. The user may add or edit these codes directly on the enterable grid.

Creating, Reviewing or Editing User-defined Codes

Step	Creating User-defined Codes
1	Select **Open** from the **File** menu (**Ctrl+O**).



Step	Creating User-defined Codes (continued)
2	Select a category from the **Categories** list and a type from the **Type** list. The Categories list refers to the area of the system to which the code is related, such as Subscribers/Members, Providers/Networks, Claims Processing, or Plan Codes.
3	Select **OK**.
4	The **Code/Description/Filter** grid displays the list of codes selected.

Step	Creating User-defined Codes (continued)
5	Select **Add** from the **Edit** menu (**Alt+E+A**), or place the cursor in the last row and select **ENTER** to continue entering the new User-defined code. Indicate a Code, Description, and Filter.
6	Select the line in the grid to delete and select **Delete** from the **Edit** menu (**Alt+E+D**) to remove a row of information.

Note: The code entered must be the same size or smaller than the Value Length displayed in the Record Information area (top of the screen). DO NOT use the code NONE or None, as it is a system-supplied default value that that may be selected if the Field is chosen by mistake.

Filtering User-defined Codes

Step	Filtering User-defined Codes
1	Select the line in the grid that shows the code and its description.
2	Enter a code in the **Filter** column to identify the appropriate value Facets uses for a unique set of reasons to be applied when saving a Prospective UM review. For example, the filter code “CO” represents the status of “Complete”, and it should be assigned to user-defined Service Status Reason codes and descriptions that identify why the Prospective UM review was saved in a status of “Complete”. If this is done correctly, when an end-user saves a Prospective UM review with a status of “complete,” only those status reasons that had either a filter code of “CO” or those that had no filter code will be available for selection.

In the above example, the 2-character Filter code is a TriZetto supplied code based on the saving status of a Prospective UM review.

Keep in Mind...

Filters are available on a limited number of user-defined codes, such as the "Status Reasons" in Customer Service, Claims Processing, Case Management, and Prospective UM applications, as well as the "Quality Assurance Items" in the Provider application.

Some filter codes are user-defined, and those codes relate to specific user-defined codes that may be defined in this application. Contact your TriZetto Product Consultant associate for more detailed information concerning which user-defined codes utilize the filter functionality.

If the **Filter** field is left blank, the user-defined code for that Category and Type will display for all filtered options in the appropriate fields.

Explanation Codes Application

Use this application to view or edit explanations that generate when error or warning situations arise throughout Facets. Explanation Codes may be supplied by TriZetto (hard-coded) or user-defined. The hard-coded, system-generated Explanation Codes explain system-generated disallow situations. For example, the disallow codes that begin with the letter "S" explain disallow situations regarding a type of eligibility disallow (Subscriber terminated, Group terminated, Provider terminated).

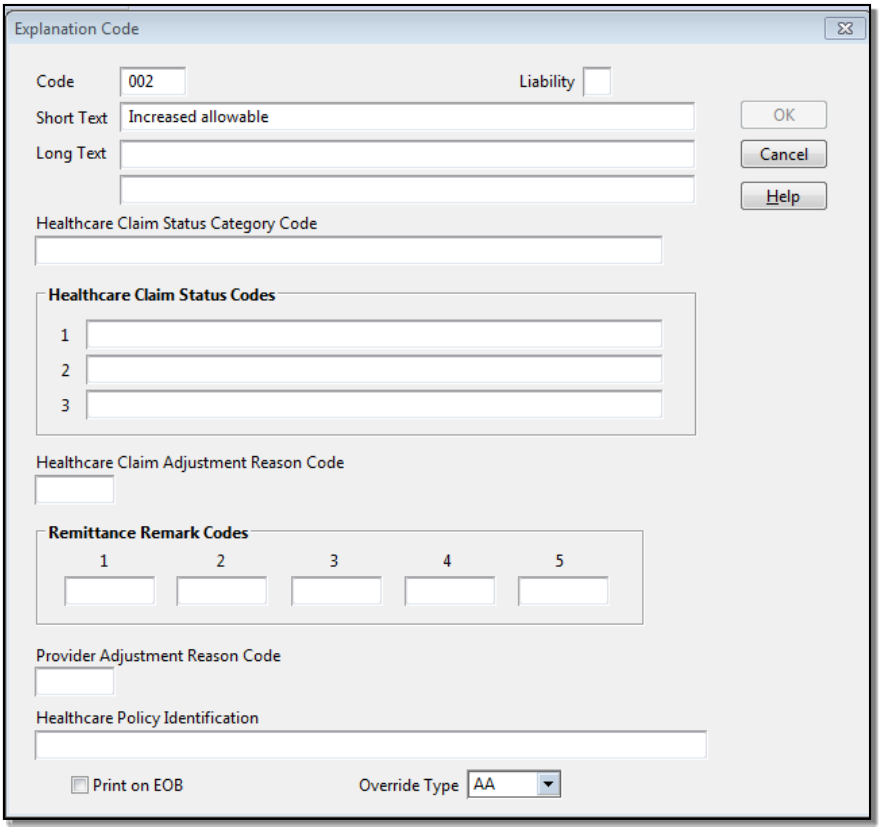
Explanation Section

This section displays all Explanation Codes and descriptions in Facets. The grid at the top of this Section indicates a one-line summary of each Explanation Code. Detail information about the highlighted code displays in the text-out area below the grid.

Adding an Explanation Code

Step	Adding an Explanation Code
1	Select **Add** from the **Edit** menu (**Alt+E+A**).
2	Complete the ***Explanation Code*** dialog box.
3	Select the **OK** button.
4	Select **Save** from the **File** menu (**Ctrl+S**), or select the **Save** button.

Note: Do not create any explanation codes beginning with the letters C, D, P, N, U, T, S, any lower case letters, or numerals. The code "RWD" is also hard-coded. These codes are reserved for system-generated messages. It is suggested that Facets customers use the letters B and Q, as well as upper case X and Z since these are not used by Facets logic; please note that this suggestion does imply usage of capital letters where not otherwise specified.



Field		Description
Fields denoted with an * are required.		
Code	*	This code is created to identify the status of a claim's process and/or eligibility for a parent group, group, or subgroup. The code can also be used to identify room type discounts, stoploss provisions, and when line items are disallowed during claims processing.
Liability	*	Used to indicate that amounts disallowed during claims processing; using this code should be included in an external liability calculation. **Note**: Although Facets does not calculate patient liability, the Liability indicator on the explanation code can assist in determining patient/provider liability for EOBs and reporting. When claims are processed, the disallow will be given an explanation code, depending on the reason for the disallow. When clients create EOBs, the explanation code will be associated with a Liability Indicator. Clients may vary the liability indicator to calculate patient and provider liability.

Field		Description
Short Text		Enter a brief description of the corresponding explanation code that displays on the line item during claims processing. **Note**: This is an optional field, although it is recommended that short text be present, since this is what displays during on-line processing.
Long Text		Enter a detailed description of the corresponding explanation code that may display on the "Explanation of Benefits" notification form.
Healthcare Claim Status Category Code		Enter the category code for the healthcare claim status. If this code is entered, a "Healthcare Claim Status Code" must also be entered. EDI 277 data will include this field when linked to an explanation code generated on a claim. **Note**: Facets does not perform a validation edit on this data.
Healthcare Claim Status Code 1,2,3		Enter up to three codes for the healthcare claim status. If this code is entered, a "Healthcare Claim Status Category Code" must also be entered. EDI 277 data will include this field when linked to an explanation code generated on a claim. **Note**: Facets does not perform a validation edit on this data.
Healthcare Claim Adjustment Reason Code		Enter the code for the healthcare claim adjustment reason. EDI 277 data will include this field when linked to a code generated on a claim. **Note**: Facets does not perform a validation edit on this data.
Remittance Remark Codes 1,2,3,4,5		These codes are used in the 835 to relay service specific information that cannot be described with a claim adjustment reason code. These fields must be entered in numeric order.
Provider Adjustment Reason Code		This code is mapped in the 835 data element PLB or manual check adjustment amounts. The default value is blank. This code is informational only, and Facets will not perform validation edits on this field. It is used to assist customers in meeting HIPAA requirements.

Field		Description
Healthcare Policy Identification		Enter the Healthcare Policy Identification number for the Explanation Code. This field is used by version 5010 of the EDI 835 process.
Print on EOB		Select this checkbox to print the explanation on an EOB (Explanation of Benefits). If this box is not checked, this explanation will not print. This explanation code will also display during on-line processing.
Override Type		Select the code that identifies the type of valid override for this explanation. Explanation codes are filtered by "Override Type" in the application where they are used. **Note**: Every Override Explanation Code must have the appropriate **Override Type** or it will not be accepted by Facets as valid to complete the override. The **Override Type** assigns a specific explanation code to a claim or UM override. When this explanation code appears on a claim or UM review, only those users with the appropriate level of security will be able to perform that override.

There are three uses for user-defined Explanation Codes

- **Informational:** These codes are used when information needs to be provided to the member at the time a claim is processed and paid. Possibilities of 'informational' explanation codes might be "Your name and address have been changed in our database" or "Please be sure to complete a claim form with your next submission".
- **Disallow:** A three-character code that is currently not being utilized by Facets may be assigned to generate an 'explanation' for the disallow. For example, each limit must be assigned an explanation code to generate when the limit is reached to explain the reason for the claim disallow.
- **Override:** A claims processor must enter a valid override explanation code in order to override Facets logic on the Claims or Utilization Management processing screens. The override leaves an audit trail for supervisory and reporting purposes. Explanation codes created for specific overrides must be created using the correct Override Type code that is associated with the type of override. For example, a code created to explain the override of an 'allowable amount' on a medical claim would have an Override Type of "AA" attached to it.