Service Payment

Facets 5.0
Participant Guide

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Service Rule Definition Application (SESE)

This application defines type-of-services and the rule of payment applicable to each service. Specific rules are linked to types-of-services in the Service Payment application.

In Facets, a service code is a user-defined code assigned to a set of procedure or revenue codes used to group the services together for claims processing or reporting purposes. The Service Rule Definition application allows the user to add or edit information about a specific medical service covered under a benefit plan. For example, outpatient laboratory services may include procedure codes 80002 to 88140 and may be identified by service code BLDO or LO. These codes identify the service performed by the provider.

The following are 3-types of service rules that may be established for a type-of-service:

Counter: The allowable amount for the line item is calculated by the number of units on the line item multiplied by the allowable amount for the service.

Amount: The allowable amount for the line item is not dependent on units. The line item allowable will be the flat rate defined for the service via an agreement or by Plan for an out-of-network service, regardless of the number of units on the line-item.

Disallow: The rules will use an allowable amount of "0" (zero) during claims processing and display the explanation code entered as the reason for the disallow. A Service Tier section tab will not be completed for a disallowed service.

Creating or Opening a Service Rule Definition

Step	Creating or Opening a Service Rule Definition Procedures
1	Select **New** from the **File** menu (**Ctrl+N**) to access a blank record and create a new service rule for a type-of-service. To add a new set of payment rules to an existing service code, select **Open** from the **File** menu (**Ctrl+O**). Facets will return to the Indicative section/Indicative section tab.
2	Add the new rule by selecting **Add**…**Section** from the **Edit** menu (**Alt+E+A+S**).Enter the necessary information in the **Service Rule** dialog box and select **OK**.
3	To add a new set of payment rules to an existing service code, select **Open** from the **File** menu (**Ctrl+O**). Facets will return to the Indicative section/**Indicative** section tab.

Step	Creating or Opening a Service Rule Definition Procedures
4	Select the **Service Tier** section tab and select **Add**…**Subsection** from the **Edit** menu (**Alt+E+A+B**).
5	Enter the appropriate information in the **Service Tier** dialog box and select **OK** to apply the information to that section tab grid.
6	When done adding the appropriate rules, select **File**…**Save** (**Ctrl+S**).

Note: If a Service Rule type of disallow is selected, the **Service Tier** section tab is not available. If an existing rule type is changed from Amount or Counter to Disallow, any Service Tier information will be deleted.

Indicative Section

Indicative Section Tab

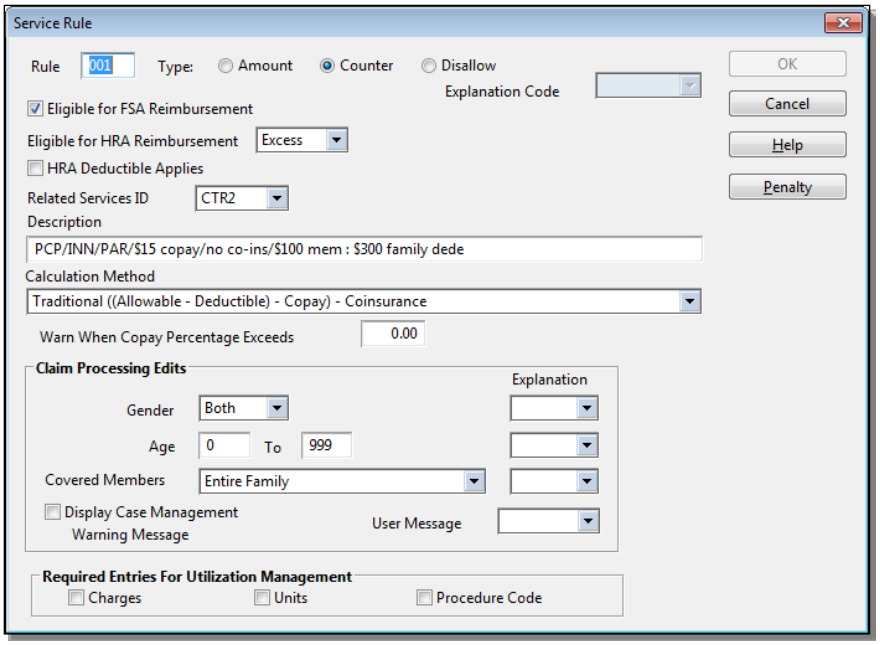
This section tab allows a user to view or edit service rules for a type-of-service. Users may identify the ID for the rule and determine if the service is to be counter-oriented, amount-oriented, or disallowed.

Note: If there are various ways of paying for the same service based on plan requirements, different rules may need to be established.

Facets reads the rule to determine information such as the following:

1. Amounts
2. Counter limits
3. Co-insurance %
4. Deductible Accumulator number
5. Co-payment

The service rule resides on the Service Payment application along with the Service ID.



Field		Description
Fields denoted with an * are required.		
Rule	*	User-defined prefix for this rule.
Type:	*	Select either Amount-oriented, Counter-oriented or Disallow.
Explanation Code		If rule is a disallow type, an explanation code must be entered.
Eligible for FSA Reimbursement		Select this checkbox if patient liability from this service is eligible for FSA reimbursement.
Eligible for HRA Reimbursement		Select whether or not products using this service rule will handle HRA reimbursements. Options include: N – No, A – All and E – Excess. **Note**: If “A” is selected, the service rule will be treated as HRA only (not covered by medical). If “E” is selected, the rule will be covered by the medical plan and reimbursed by the HRA for any excess patient liability amounts.
HRA Deductible Applies		Select this checkbox to indicate that this service is eligible for reimbursement from the HRA account.

Field		Description
		This indicator is only available when the **Eligible for HRA Reimbursement** field is set to A–All or E–Excess. [*See below for additional information on the HRA Deductible.]
Related Services ID		The prefix to indicate related services. This allows multiple services to be included in the same limits. For example, a maximum of 26 visits for chiropractic services.
Description		User-defined description for this rule.
Calculation Method:	*	Select a method of benefit calculations from the 3-below: Traditional – The deductible is applied first, followed by the co-pay. the coinsurance is applied last. Option 1 – Co-pay is applied first, then the coinsurance and deductible. Option 2 – Co-pay is applied first, then the deductible and coinsurance.
Warn When Copay Percentage Exceeds		Enter the percentage of the allowable amount to be used as the line-item's maximum co-payment. If a claim line co-payment exceeds this percentage of the service's total cost, a warning message displays; the default is $0.00 – no message appears.
Claim Processing Edits: Gender / Explanation		Does this service/rule apply to only one gender? Select the explanation to display during claims or UM review processing if the patient's gender does not match the gender entry for this service.
Claim Processing Edits: Age / Explanation		Does this service/rule have age restrictions? Select the explanation to display during claims or UM review processing if the patient's age falls outside the min/max age range defined for this service.

Field		Description
Claim Processing Edits: Covered Members / Explanation		Does this service/rule have member restrictions? Select the explanation to display during claims or UM review processing if the patient's relationship to the subscriber does not match the 'coverage type' defined for this service.
Claim Processing Edits: Display Case Management Warning Message		Check this box to indicate if this service has potential for case management. A warning displays in UM and claims processing.
Claim Processing Edits: User Message		Select a user-defined warning message to display during claims, UM or customer service processing if the user's security level requires the process to be pended for additional review.
Required Entries For Utilization Management		Select whether charges, units, and/or procedure code are required when processing a pre-auth. in Prospective UM.

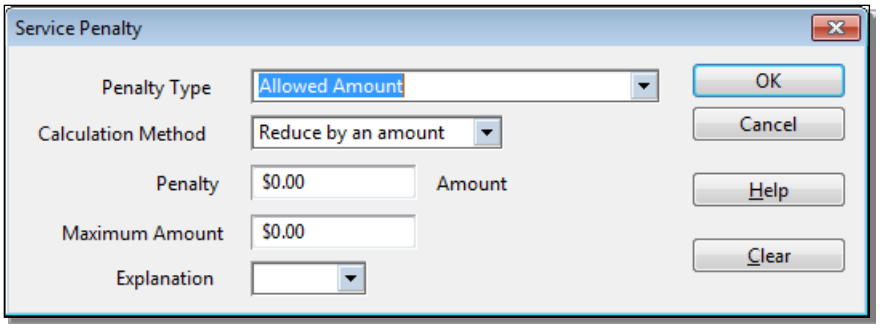
The **Service Penalty** dialog box stores information on service penalty parameters used during claims processing.

Some examples when penalties could apply include the following:

1. UM guidelines were not followed
2. Out-of-network situations
3. To discourage providers from performing specific types-of-service

A user may select to apply the penalty as a flat amount or a percentage, select to apply the penalty to the allowable or paid amount and may enter the amount which represents the maximum penalty amount to be taken.

The **Penalty** button takes the user to the **Service Penalty** dialog box.



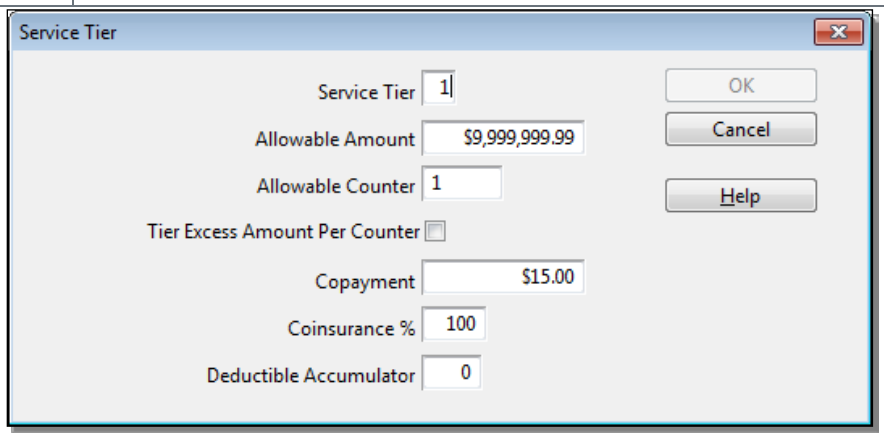
Field		Description
Penalty Type	*	Indicates from what amount the penalty will be subtracted.
Calculation Method	*	How the penalty is calculated.
Penalty	*	Dollar or percentage amount.
Maximum Amount		Maximum penalty amount to be taken.
Explanation	*	Explanation for the Penalty.

Service Tier Section Tab

Use this section tab to establish the allowable, counter, deductible, copayment, and coinsurance amounts for each tier. Each row in the section tab grid shows tiering information for the rule selected in the section grid at the top of the screen.

Entering Service Tier Information

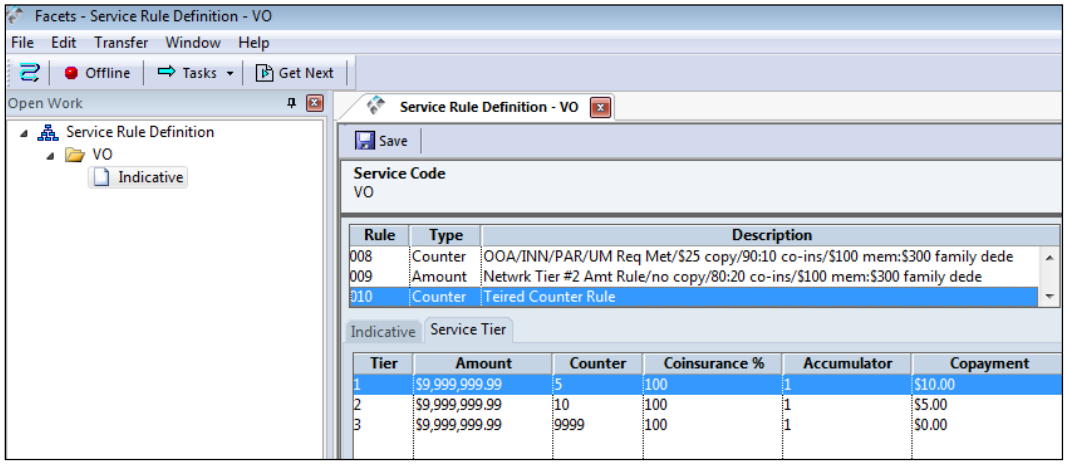
Step	Entering Service Tier Information Procedures
1	From the menu, select **Add**…**Subsection** from the **Edit** menu (**Alt+E+A+S**) to obtain the **Service Tier** dialog box.



Step	Entering Service Tier Information Procedures (continued)
2	Enter information pertaining to the tier-row being established.
3	Select **OK** to apply the information entered to the section tab grid.
4	Select **Save** from the **File** menu (**Ctrl+S**) to save the information to the database.

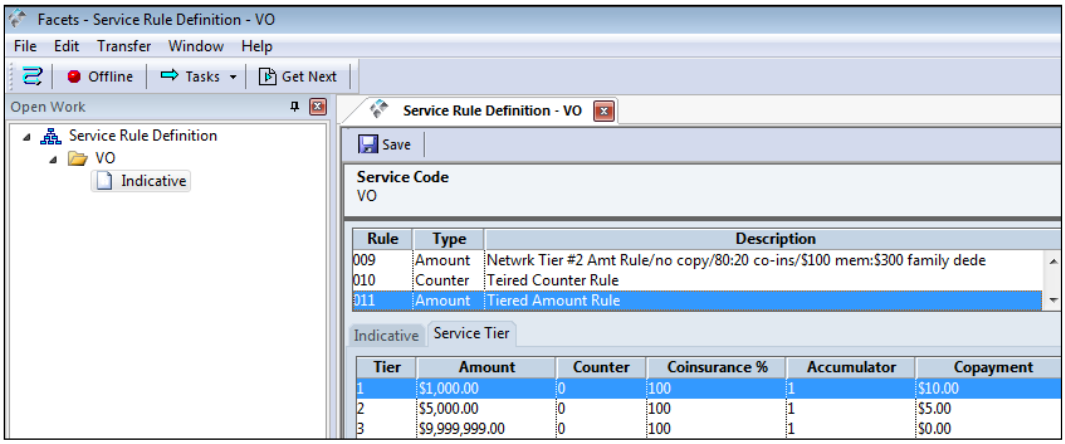
Field		Description
Fields denoted with an * are required.		
Service Tier	*	Used to tier this service code.
Allowable Amount	*	Allowable dollar amount. If no maximum, use all 9's. **Note**: Either an Allowable Amount or an Allowable Counter will need to be entered in order to apply this tier to the grid.
Allowable Counter	*	Allowable counters (up to 9,999). If no maximum, use all 9's. **Note**: Either an Allowable Amount or an Allowable Counter will need to be entered in order to apply this tier to the grid.
Tier Excess Amount Per Counter		Checkbox to indicate if tiering excess to next row.
Co-payment		Dollar amount of any co-payment.
Coinsurance %		Percentage MCO is responsible for.
Deductible Accumulator		Points to appropriate accumulator row on the Deductible Rules record.

Use the ***Service Tier*** section tab to establish the allowable deductible, copay, and coinsurance for each tier. The user may establish up to nine tiers.



In this example, each of the first 5 units would be subject to a $10 copay; the next 10 would have a $5 copay taken, while anything past the first 15 units would not have any copay taken.

When 25 units are billed, $100 copay would be taken; (5 x $10) + (10 x $5).



In this example, the first $1,000 would be subject to a $10 copay.

The next $4,000 would have a $5 copay taken, while anything past $5,000 would not have any copay taken.

When $10,000 is billed, $15 copay would be taken ($10 + $5).

Assuming the calculation method is ‘allowable-copay-coinsurance’, the amount payable would be $9,985.

This amount is calculated by subtracting the $10 copay from $1,000 for an amount of $990 x 100% for Tier 1.

For Tier 2, the calculation is $4,000 - $5 copay = $3,995 x 100%.

The amount for Tier 3 is calculated by multiplying $5,000 by 100% (no copay).

The total payable for all three tiers is $9,985.

Service Payment Application (SEPY)

The Service Payment record lists the Service ID and rule that will calculate how the payment will be made, i.e. co-payment amount, coinsurance, and deductible information. The Service Payment application allows the user to link service rules to types-of-service. These types-of-service may be linked to Experience and Accounting Categories, which are used for reporting purposes and claim fund mapping. The Service Payment record is a Product Variable Component and may be used to vary payment based on the provider, pre-authorization and referral guidelines entered.

Indicative Section

This section displays all service payment codes and rules to be accessed for all claims processed under plans using this product prefix.

Field		Description
Fields denoted with an * are required.		
Service ID	*	From the drop-down selection, select the Service ID code used to group a set of procedures or services together that are performed by a provider for claims or limit processing, accumulation, fee calculation, payment, or reporting purposes.
Rule	*	Select a code to differentiate payment rules for the same type-of-service (TOS).
Alt. Rule		Enter the alternate service rule that will be used when the condition selected in the **Alt. Rule Condition** field occurs. This field accommodates alternate service rule logic for medical utilization edits. During claims processing, an alternate service rule will be used as the service rule on the claim line item.
Alt. Rule Condition		Select the condition that must be present on a claim line item to invoke the alternate service rule entered in the **Alt. Rule** field above. This field accommodates alternate service rule logic for medical utilization edits. During claims processing, an alternate service rule will be used as the service rule on the claim line item.
Experience		This field may be used to match claims to

Field		Description
Category		expenses. Each claim line is assigned an Experience Category during processing. Because the Experience Category also appears on the Billing Component application, the Experience Category listed on the claim may be compared to the Experience Category listed on each billing component to match income and expenses.
Accounting Category		This field is used in the calculation of a capitation/risk fund account. When a claim is processed, Facets uses the accounting category on the Service Payment application, along with other criteria, to map to a particular fund. The criteria is specified on the Claim/Encounter Mapping component (CRCL).

Service Related Parameters Application (SERL)

The Service Related Parameters application is used to establish limits that cannot be defined on the Limit Rules (Variable Component) application.

After the file is set-up and saved, the Relation ID should then be added to all related Service Rules (by updating the **Related Services ID** field in the Service Rule Definition application) that will recognize the related period and parameter settings defined by the Relation ID in the Service Related Parameters application.

The following list indicates why or when the Service Related Parameters application should be used in conjunction with the Service Rule Definition application:

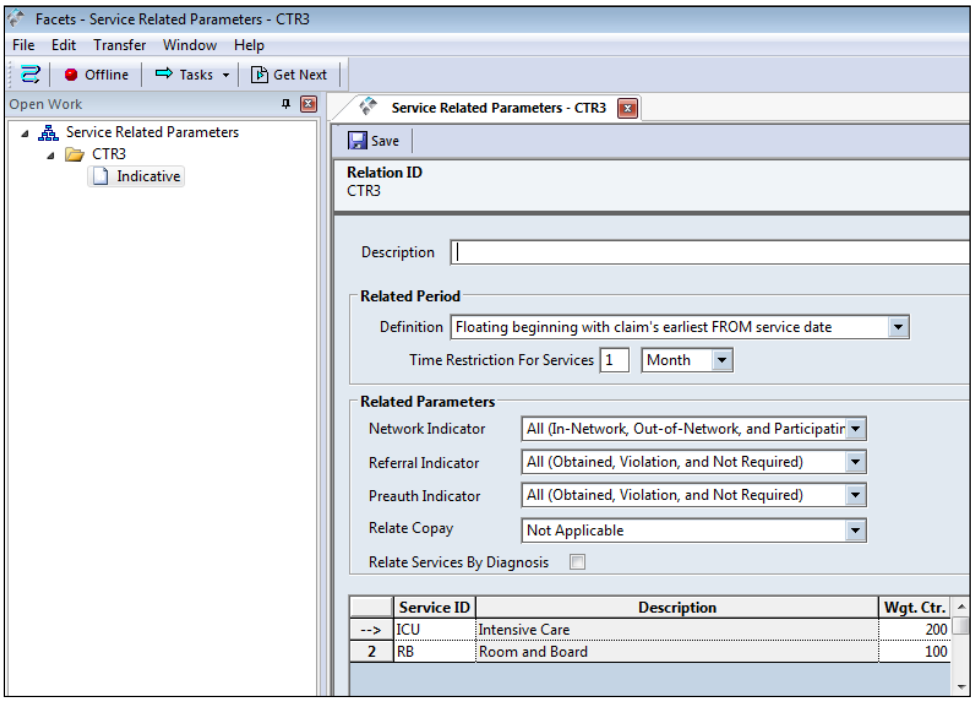
1. Define limits outside of the usual plan year, calendar year and lifetime time periods identified on the Limit Rules application
2. Relate Co-Pay Per Day By Provider
3. Relate services by diagnosis code outside of the usual plan year, calendar year, and lifetime time periods identified on the Limit Rules application
4. Expand tiering on a ‘service rule’ beyond a line item level and have it relate to an entire claim, as well as future claims processed in the ‘related time period’ indicated on the Service Related Parameters application
5. Relate Copay Per Confinement
6. Relate Copay Per Day By Provider Per Relation ID

Indicative Section

Using this application, services may be related together for benefit limits and mandate periods other than plan year or lifetime (however, no accumulators will be created). Only those services being linked together for the purposes of setting-up a maximum limit need to be listed in a Service Related Parameters record.

Example: Two different types of hospital room and board services might need to be related to each other because a plan limits the number of days in the hospital per month. Based on the type of Room and Board service being billed and the value attached to that service, Facets may properly calculate the number of units. For this to happen, all services relating to each other must be set with a proper value (or weight):

1. ICU = 200 = two-units (i.e. 2-days)
2. RB = 100 = one-unit (i.e. 1-day)



Field		Description
Fields denoted with an * are required.		
Description		User-defined description of the service related parameter. Limited to 70 Characters.
Related Period: Definition	*	Type of period to be related. Once this time period has elapsed without any related services occurring, a new service period will begin and counters

Field		Description
		will be reset.
Related Period: Time Restrictions for Services	*	Time Period (e.g.: one month, 2 years, etc.).
Related Parameters: Network Indicator		Define which providers will be affected by these parameters.
Related Parameters: Referral Indicator		Indicate whether this will apply for referral services.
Related Parameters: Preauth Indicator		Indicate whether this will apply for pre-authorized services.
Related Parameters: Relate Copay		Select a value used to relate one or more services to a single copayment amount.
Related Parameters: Relate Services by Diagnosis		Services listed with the same diagnosis will be related.
Service ID		Type-of-Service (e.g.: VO for Office Visit).
Wgt. Ctr.		Weighted Counter (0-999). 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 to the accumulators.

Medical Utilization Edits Overview

The purpose of the Medical Utilization Edits by Service and Medical Utilization Edits by Procedure applications is to prevent the inappropriate utilization of medical services by establishing multiple “if, then” scenarios. The user can also apply alternate service rule logic through the Service Payment application.

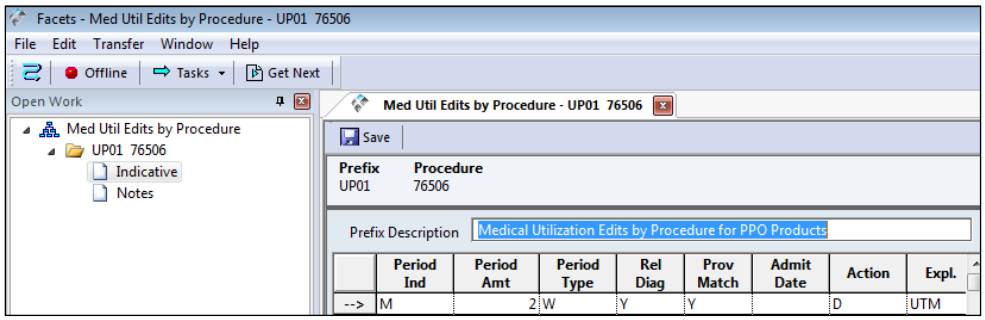
Claims processing reads the medical utilization edits prior to payment and processes the line items in accordance with the established criteria. When an alternate service rule is designated, that rule will be captured as the Service Rule in the claim line item.

Medical Utilization Edits by Procedure Application (UTIP)

The Medical Utilization Edits by Procedure application is an optional product component and is found in the Medical Plan application group. It allows the user to establish dependencies based on a procedure code's relationship to other Service IDs. The user may define criteria based on diagnosis, provider and admit date, specify a time frame during which related services or procedures would have been performed in order for the edit to be applied, and identify the action that will be invoked when a medical utilization edit applies.

Indicative Section

This section allows the user to enter a set of possible scenarios that may result in inappropriate utilization of medical services and procedures for a specified procedure. It contains an enterable grid in which the user may add, insert, or delete rows of criteria that are required in order for medical utilization edits to be applied to that procedure. This section also includes two section tabs, which are used to define related services or procedures that would have been performed in order to initiate medical utilization edits.



Field		Description
Fields denoted with an * are required.		
Prefix Description		Enter a brief description of this Medical Utilization Edits by Procedure prefix.
Period Ind		Select the type of period to be calculated from the initial procedure. Valid values: D – Days, M – Months, and Y – Years.
Period Amt		Select the value that corresponds with the **Period Ind** field to establish a time period. For example, 30 Days, 12 Months, or 2 Years. Valid values: 1-999.
Period Type		Select the related period to apply to this

Field		Description
		utilization edit. Valid values: B – Beyond-Proc/Service Code (allow the current service within the time period of the related procedure/s or service/s, but do not allow the current procedure after that period has elapsed), W – Within-Proc/Service Code (do not allow the current service if performed within the time period of the related procedures or services), and N – Not Within-Proc/Service Code (do not allow the current service if the related procedure or service ID was not performed within the defined time period.)
Rel Diag		Select the indicator to determine whether the related diagnosis on the current line item and the related line item have to match in order for a utilization edit to apply.
Prov Match		Select a code to indicate whether the provider ID on the current line item and the provider ID on the related line item have to match in order for a utilization edit to apply.
Admit Date		Select a code to indicate whether the admit date on the current line item and the admit date on the related line item have to match in order for a utilization edit to apply.
Action		Select the action to take when a utilization edit is applied. **Note:** In order for the 'alternate service rule' logic to apply, the user will have to enter an alternate service rule in the **Alt. Rule** field of the Service Payment application. This lets the user designate a rule that will be applied when conditions in the **Alt. Rule Condition** field (of the Service Payment application) are present.
Expl.		Select the explanation code to be used for the disallow when a line item is

Field		Description
		denied due to the application of medical utilization edits.

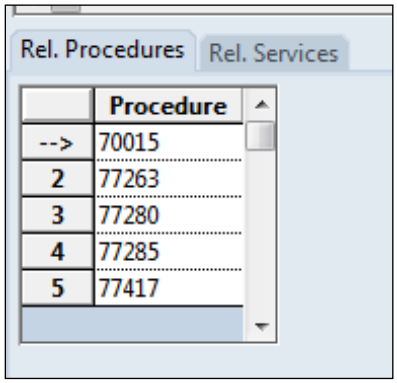
Note: The **Related Diagnosis**, **Provider Match,** and **Admit Date** fields are read as 'and' criteria. For example, if all three columns contain "Y", line items in history must have the same related diagnosis, provider and admit date as the current line item in order for a match to occur.

The hierarchy read for this table is as follows:

1. Procedure code to Procedure code
2. Procedure code to Service code
3. Service code to Procedure code
4. Service code to Service code

Related Procedures Section Tab

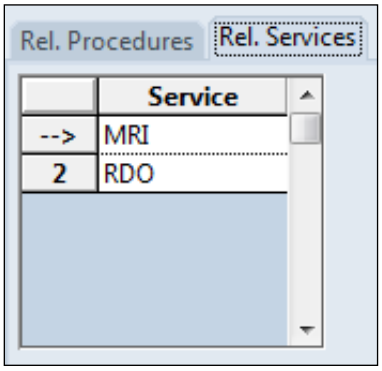
This section tab is used to identify the procedure codes that will be compared to the current claim's line item in order to determine whether to initiate a read of the medical utilization edits for this procedure.



Note: If there is more than one procedure code entered in the section tab grid, they will be read as 'or' procedure codes.

Related Services Section Tab

This section tab is used to identify the services that will be compared to the current claim's line item in order to determine whether to initiate a read of the medical utilization edits for this procedure.



Note: If there is more than one service code entered in the section tab grid, they will be read as 'or' service ID codes.

Claims Adjudication Routine for Medical Utilization Edits by Service

During claims adjudication, Facets reviews the line item procedure code. It then reads the Medical Utilization Edits by Procedure application to determine if there is a relationship that matches to the claim's current procedure code. If one is found, it reviews claims history for line items containing a procedure code or Service ID equal to those identified in the **Rel. Services** and **Rel. Procedures** section tabs. If a match is found based on the defined time period and relationship parameters, Facets will either deny, warn, or apply an alternate service rule to the current claim line item based on the value found in the **Action** field on the corresponding row.

Medical Utilization Edits by Service Application (UTSE)

The Medical Utilization Edits by Service application is an optional product component and is found in the Medical Plan application group. It allows the user to establish dependencies based on a service ID's relationship to other service IDs. The user can define criteria based on diagnosis, provider, and admit date, specify a time frame during which related services or procedures would have been performed in order for the edit to apply, and identify the action that will be invoked when a medical utilization edit applies.