Core Facets Pricing

Facets 5.0
Participant Guide

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Service Pricing

Service ID Descriptions Application (SEDS)

When configuring pricing in Facets the Service ID needs to be defined in the Service ID Descriptions Application.

Creating Service ID Descriptions

Step	Creating Service ID Descriptions Procedures
1	Double click to open the Service ID Descriptions Application.
2	Select **Add** from the **Edit** menu (**ALT+E, A**) to add a new row to the Service ID Descriptions Table.
3	Enter the **Service ID** and Description.
4	Select **Type** from the drop-down menu.
5	**Save**.

Field	Description
Service ID	Groups a set of procedures or services for claims or limit processing, accumulation, fee calculation, payment, or reporting purposes.
Description	User-defined description for a service; up to 70-characters.
Type	Used to further classify the service for clinical editing since the same CPT code may be used to report multiple types-of-services. Identifies a service as surgery, assistant surgery, or anesthesia.

After the service is added, pricing applications should be set up in the following order:

1. R&C Schedule (only used for Facets pricing)
2. Service Pricing (required for both Facets and NetworX Pricer pricing)
3. Service Definition (required for both Facets and NetworX Pricer pricing)

R&C/Schedule, Medical Application (IPRS)

Some plans use reasonable & customary (R&C) pricing or fee schedules to determine the maximum allowable price of a medical service. Use this application to add or edit a procedure and its price(s) or rate(s). Each procedure code and the rate(s) are identified by a unique prefix in Facets using this application.

Creating or Accessing an R&C/Schedule

Step	Creating or Accessing an R&C/Schedule Procedures
1	Select **New** (**Ctrl+N**) or **Open** (**Ctrl+O**) from the **File** menu to open an existing prefix. A **New** or **Open** dialog box will appear.
2	Enter the prefix and select **OK**. Facets will return to the Indicative section.
3	A user may also perform a search for a prefix by selecting the **Search** button (**Alt+S**).

Indicative Section

This section contains an enterable grid used to define specific geographic areas (if the Pricing Method is Reasonable & Customary), or may be accessed to obtain a price for the service on the claim (Pricing Method = Schedule). Set-up in this application is the procedure code and the corresponding effective dates, as well as the procedure price/rates. Add or make changes directly on the grid.

Field	Description
Prefix Description	Enter a description for this R&C/ Schedule.
Pointer	Enter the code that will match the pointer entered on the Service Pricing application.
Effective date	Enter the effective date in MM/DD/YY format.
Termination date	Enter the termination date in MM/DD/YY format.
Rate	Enter the allowable amount for this procedure code.
Percent	Enter the discount percentage for this procedure code (the percentage taken against the charges). This percentage is used to calculate the price. **Note**: Users may set-up this application to price services based on a percentage of the charges and then take the 'lesser of' that amount or the listed schedule rate. **Note**: The Percent field is not automatically populated. The user must manually enter either 100% or 999% or Tab through for a fee schedule price to be used. The user must also update this field each time new data is downloaded.

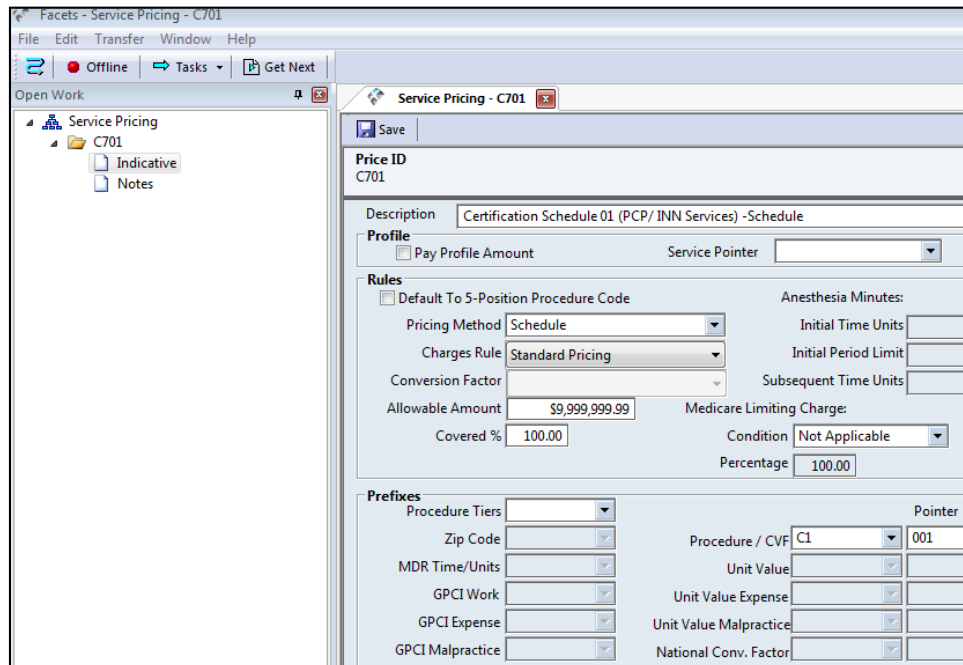## Using Pointers in R&C/Schedule

A user may assign dollar amounts to procedure codes and vary the amounts by using a pointer. For a Schedule-type pricing method on the Service Pricing record, pointers are set-up in the R&C / Schedule, Medical application. During claims processing, the R&C / Schedule is accessed to determine a price for the procedure code and pointer.

Service Pricing Application (SEPC)

This application identifies the Pricing Method (Schedule, Rate, MDR, Conversion Factor, R&C, DRG, Anesthesia, or All-inclusive or R&B per diem / per case) used for a type-of-service. Depending on the Pricing Method selected, other components may need to be set-up and attached to the application.

Indicative Section

This section allows users to view or edit service requirements specific to a product and/or a network provider relationship. Only the appropriate fields (based on the Pricing Method chosen) will be activated.

Field	Description
Description	User-defined description of the Service Pricing record.
Pay Profile Amount	Check this box to indicate that a Profile Price takes precedence over this pricing. **Note**: If NetworXPricer is utilized, this checkbox has no functionality.
Service Pointer	Select the Service Pointer used to distinguish a profile when a provider has multiple profiles under the same Provider ID.
Rules: Default to 5-Position Procedure Code	Select this check box to direct Facets to use the first 5-digits of a procedure code if it cannot find the full 7-digit code.
Rules: Pricing Method	Select from the drop-down box.
Rules: Charges Rule	Select the code to indicate the action taken if this service allows a greater amount than the actual charges. The options include: Warn and Pay Allowable (B), Standard (blank), Pay Allowable (P), Warn Processor (W). This field works in-conjunction with the "Pay Profile Amount" indicator. Facets will use the profile amount when the Pay Profile amount has been selected regardless of whether or not the profile price is less than the other allowable pricing amounts captured in the pricing routine. However, if the profile amount should be paid when it is greater than the charges submitted for a given procedure, the Pay Allowable or Warn and Pay Allowable option must be invoked.
Rules: Conversion Factor	Indicate if conversion factor varies by area.
Rules: Allowable Amount	Indicate if there is a maximum allowable amount for a service. Facets will compare this against any other price calculation methods for a particular service. The default is all 9s.
Rules: Covered %	Indicates what percentage of price is allowed; default = 100%.
Rules:	This provides the ability to reimburse providers who

Field	Description
Medicare Limiting Charge: Condition	do not accept Medicare assignments at a different level than those who do accept Medicare assignments. Select the condition that must be present for Medicare Limiting Charge to be applied. Valid values include: "Not Applicable" and "Provider is Payee, Does Not Accept Medicare Assignment". When the Medicare Limiting Charge Condition is set to "Provider is Payee, Does Not Accept Medicare Assignment," and both conditions exist on the claim, Facets multiplies the amount generated by the pricing routine by the value in the **Medicare Limiting Charge Percentage** field. This new price is then compared to the billed charge and Facets uses the lesser of the two amounts as the final pricing amount. Medicare Limiting Charge functionality is used in Hospital and Medical claims processing; it is ignored during the Utilization Management pricing routine. **Note**: Medicare Limiting Charge functionality is only available when the **Charges Rule** field is set to "Standard Pricing". If this field has any other value, Facets generates an error message.

Note: Only the appropriate fields (based on the Pricing Method chosen) will be active/enabled on the Service Pricing record.

Service Definition Application (SEDF/AGSE)

The Service Definition application lists all services that may be provided, the Pricing ID that applies, and the UM pre-authorization and referral requirements for each type-of-service.

This application allows the user to set service pricing and other requirements that may be specific to either a product and/or a Network-Provider Relationship. For example, non-network provider services may not need to be capitated, while some network providers might have a mix of fee-for-service and capitated services. In this situation, the services would access different Service Definition prefixes.

Each Provider Agreement will contain a Service Definition (AGSE) specific to providers tied to that agreement. In addition, a Service Definition (SEDF) will also exist at the product-level to price services for truly out-of-network providers (providers who do not have an agreement with the member's plan.) The Service Definition loaded to the product is the default Service Definition identified as SEDF. When it is loaded to the Medical Provider Agreement, the Service Definition is identified as AGSE. The only difference between the two is the label SEDF vs. AGSE; the same application is used in both cases.
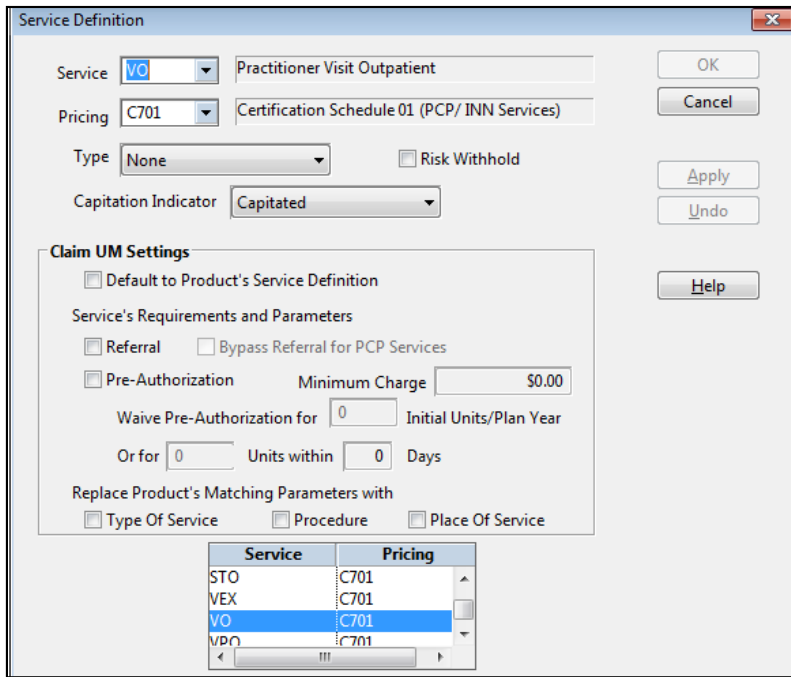
Indicative Section

This section allows the user to view or edit service requirements specific to either a product and/or a provider agreement. This includes detailed Claim/UM settings information for a selected service row in the grid. The user may view whether or not referrals or pre-authorizations apply to the specified procedure code range in the row, the minimum pre-authorization charge, and whether or not a waiver applies to the pre-authorization setting.

Adding a Service Definition

Step	Adding a Service Definition Procedures
1	To add a row, the user will select **Add**…**Section** from the **Edit** menu (**Alt+E+A+S**). The **Add** dialog box displays.
2	Enter the appropriate date.
3	Select **OK**.
4	Select **Add**…**Subsection** from the **Edit** menu (**Alt+E+A+B**). The **Service Definition** dialog box will display.

Complete the required information and any additional fields (e.g., pre-authorization and referral requirements).

Step	Adding a Service Definition Procedures (continued)
5	Complete the required information and any additional fields (e.g., pre-authorization and referral requirements).
6	Select the **Apply** button to add this code to the grid at the bottom of the dialog box. An additional code may then be added.
7	When done adding the necessary codes, select **OK.**
8	Select **Save** from the **File** menu (**Ctrl+S**) to save the information entered.

Field	Description
Service	Select the Service from the drop-down box.
Pricing	Select the Service Pricing record for this service.
Type: Primary and Secondary	Forms the pricing base when both primary and secondary services are performed on a single day and the pricing allowable is linked to the primary service. Secondary services are rolled-up into the primary pricing allowable
Type: Room and Board	This value is used to match UM confinement reviews. If Room and Board types-of-services are not mapped to a Room and Board type, this match will not occur. Also, the **Type of Bill** fields on the **Hospital Claims Processing** screen must equal an in-patient value,

Field	Description
	which is hard-coded logic.
Type: ASC Primary	If a service code is designated as an ASC primary procedure, all other Service Definition types appearing on the claim will roll into this ASC primary procedure.

*In claims processing, Facets checks for pre-authorization waivers based on the units identified for a type-of-service indicated on the Service Definition. Facets checks claims in history for the plan year and the type-of-service to determine if the submitted visits are the initial visits for that service. If this is the case, and a pre-authorization is required for that type-of-service, Facets will process the units as if the pre-authorization is not required. If the provider's record indicates a pre-authorization is required for all services, the Claims Processing applications will not waive the pre-authorization requirements for initial visits.

Note: If the number of units on a claim-line for a type of service is greater than the number of initial units that can be waived for a pre-authorization based on Service Definition requirements, the claim line will have to be split.

Utilization Management Requirements Hierarchy

The hierarchy for a pre-authorization read in Facets for an in-network and/or a contracted out-of-network provider is:

1. The provider's record
2. The Procedure UM Definition application/IPMC
3. The Procedure Edit Criteria application/IPCR
4. The Procedure application/AGIP (found in the Medical Provider Agreement application group)
5. The Service Definition application/AGSE (and if 'set to default' is indicated, Facets will refer to the Service Definition/SEDF on the product)
6. The Diagnosis Edit Criteria application/IDCR

For an out-of-network provider, the read will be as follows:

1. The provider's record
2. The Procedure UM Definition application/IPMC
3. The Procedure Edit Criteria application/IPCR
4. The Service Definition/SEDF on the Product
5. The Diagnosis Edit Criteria application/IDCR

NetworX Application Group

The NetworX application group provides an alternate pricing method for creating contract terms for institutional and professional pricing.

# Medical Fee Schedules Application

The Medical Fee Schedules application is used to create and maintain medical fee schedule information and to maintain schedule procedures. Fee schedules define how providers are reimbursed for a procedure or service.
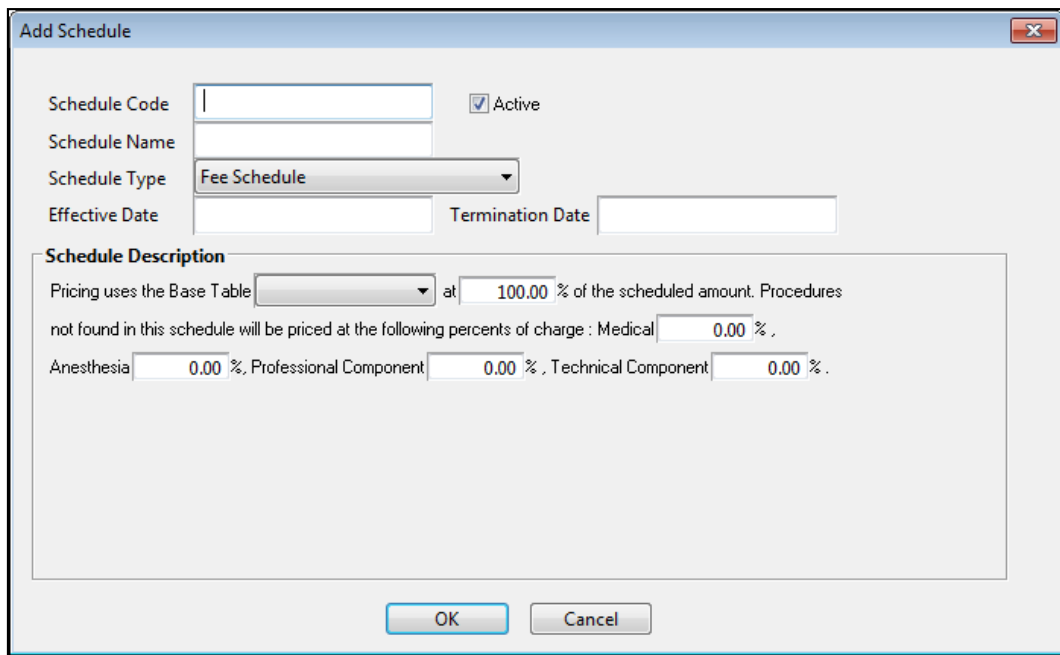
Creating a NetworX Medical Fee Schedule

Step	Creating a NetworX Medical Fee Schedule Procedures
1	In the NetworX application group, select the Medical Fee Schedules application.
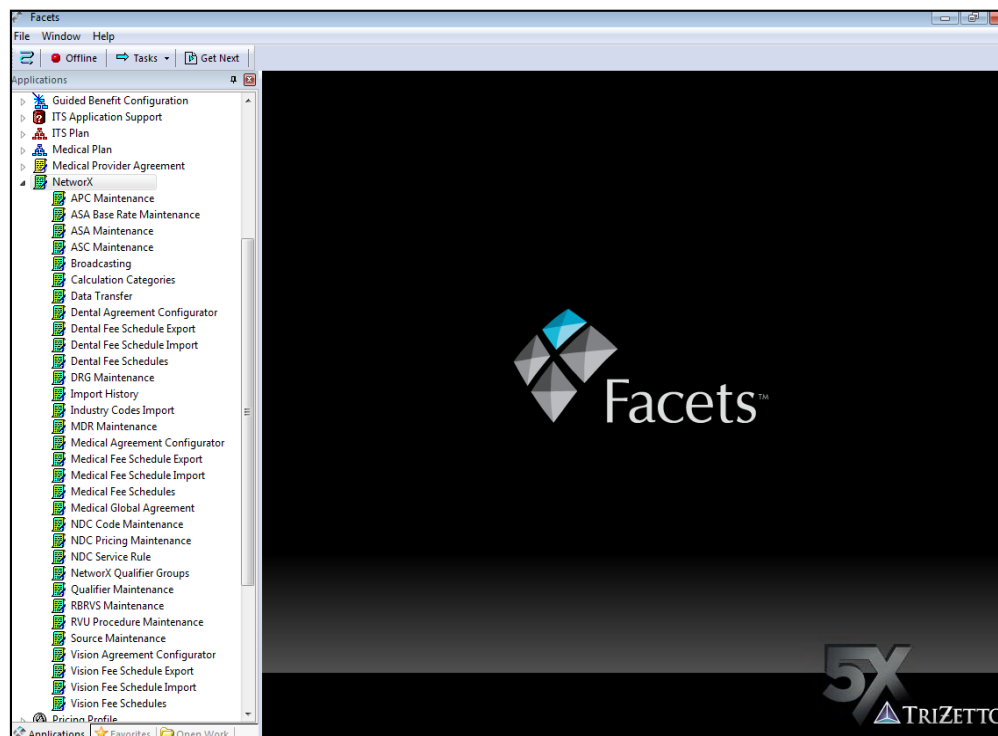
Step	Creating a NetworX Medical Fee Schedule Procedures (continued)
2	Select **Add** from the **Edit** menu (**Alt+E+A**).
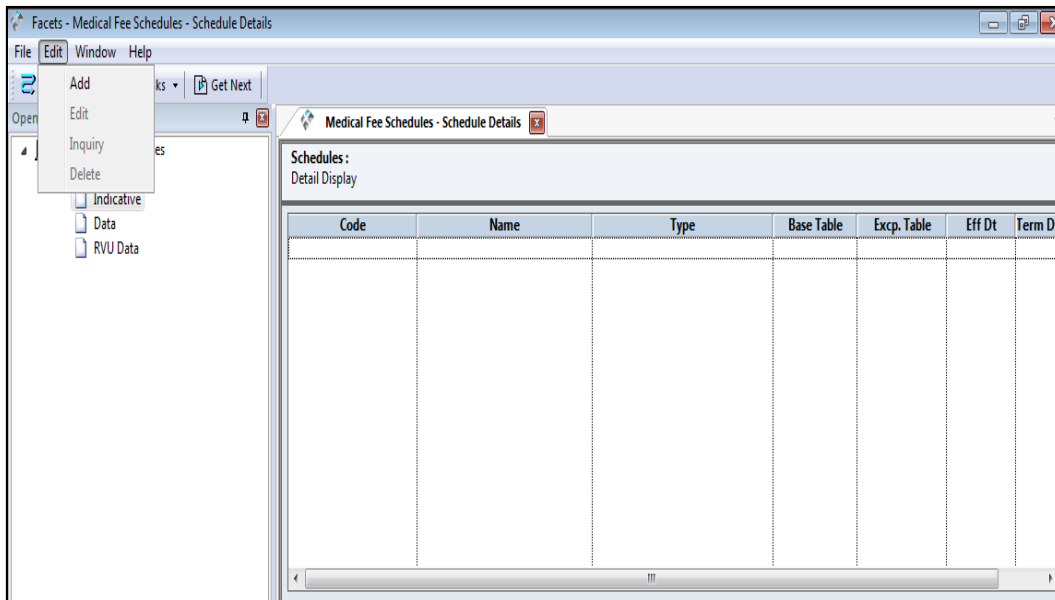
The **Add Schedule** dialog box appears.

| Step	Creating a NetworX Medical Fee Schedule Procedures (continued)
3	Complete the required fields: **Schedule Code**, **Schedule Name**, **Schedule Type** and **Effective Date**. **Note**: If the **Termination Date** field is left blank, a system-generated date of "12/31/9999" is inserted.
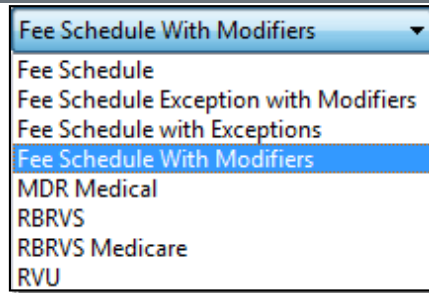
Note: Once saved, the combination of Schedule Code and Schedule Type cannot be changed. The "**Active**" checkbox not only makes the schedule usable, it also makes it visible by default.

Step	Creating a NetworX Medical Fee Schedule Procedures (continued)
4	From the **Base Table** drop-down list, select a previously created Base Table, or ^new^.

Step	Creating a NetworX Medical Fee Schedule Procedures (continued)
5	Complete the other fields as required. They will vary based on the selected Schedule Type.
6	Click **OK** to create the new Fee Schedule.

The new Fee Schedule is listed in the available Fee Schedule grid. When a Fee Schedule is highlighted in the grid, the detail of the schedule displays in the area below.
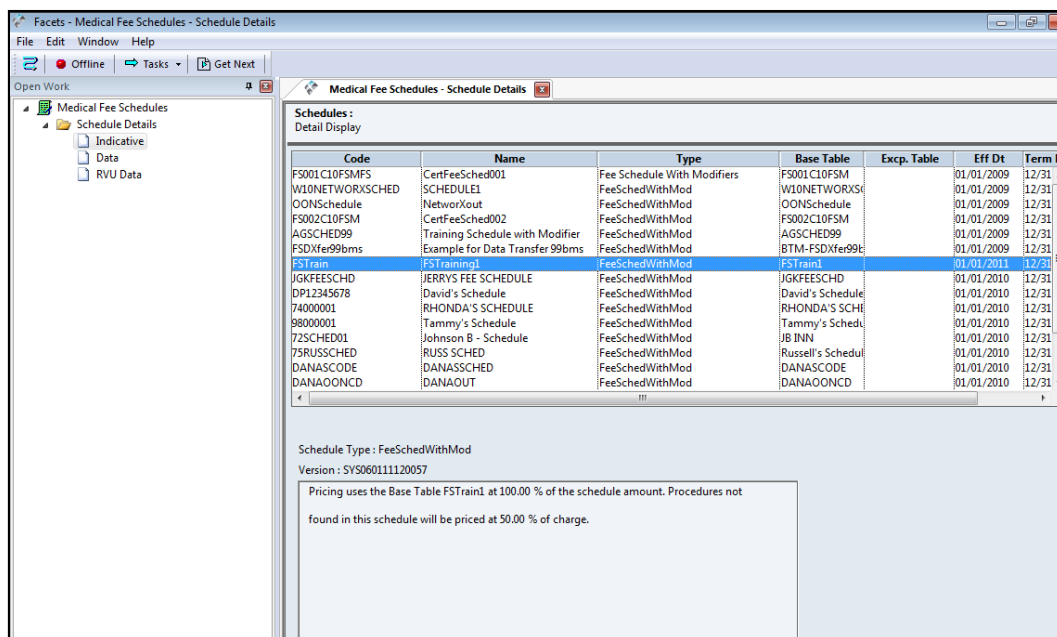
A Base Table holds procedure codes and scheduled amounts for specific types of NetworX Fee Schedules.
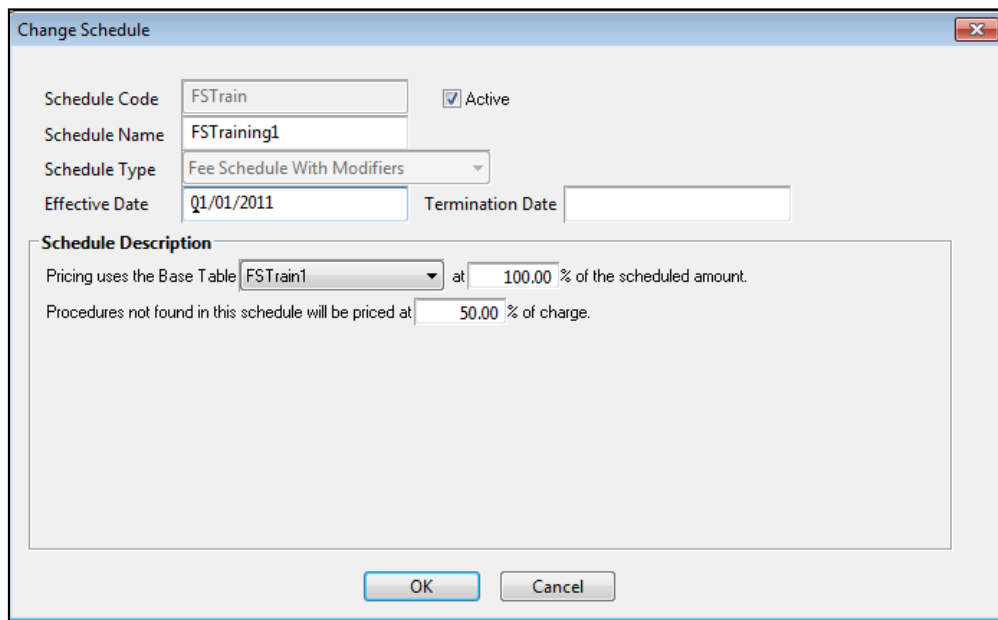
Adding a New Base Table to a Fee Schedule

Step	Adding a New Base Table to a Fee Schedule Procedures
1	Open an existing Fee Schedule from the Medical Fee Schedules application found in the NetworX application group.
2	To add a Base Table to an existing Fee Schedule, highlight that Fee Schedule and select **Edit** from the **Edit** menu (**Alt+E+E**).
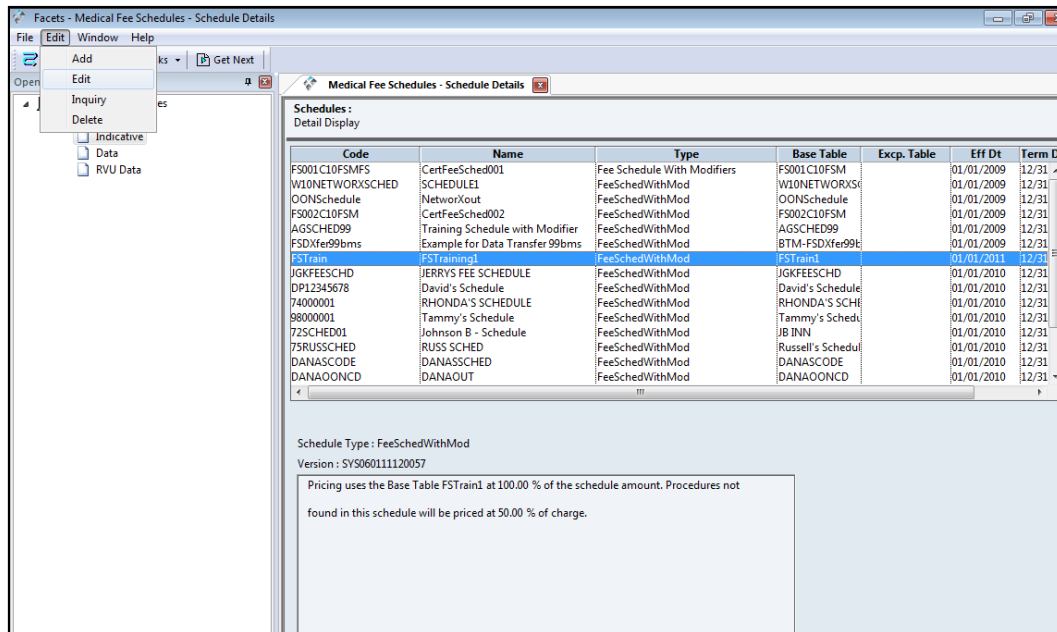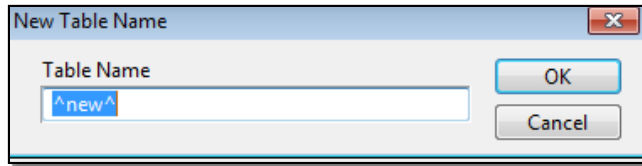
The **Change Schedule** dialog box appears.

Step	Adding a New Base Table to a Fee Schedule Procedures (continued)
3	In the **Schedule Description** area of the dialog box, select the 'base table' drop-down field and choose ^new^.
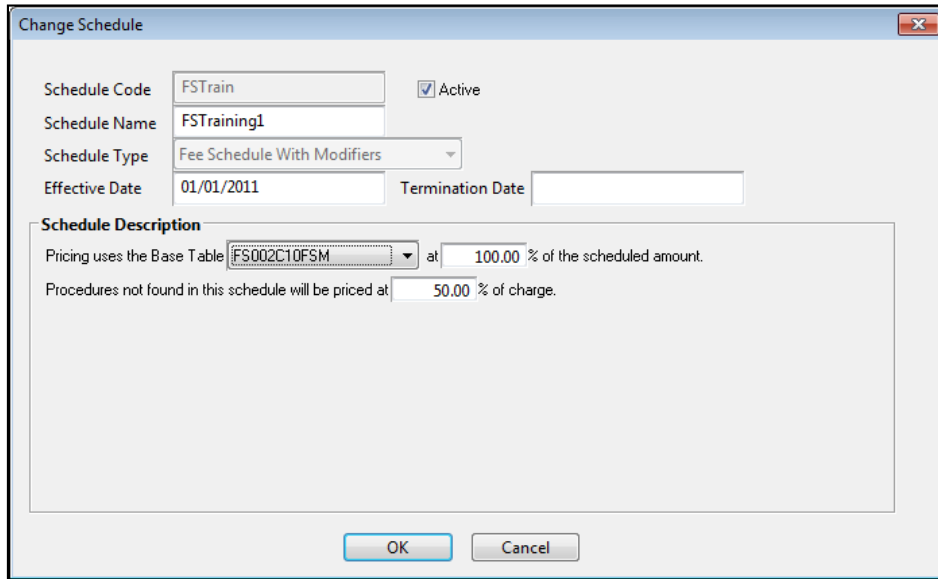
Step	Adding a New Base Table to a Fee Schedule Procedures (continued)
4	Enter a name for the new Base Table. **Note**: Best practice suggests that the new table's name should be a close variant of the Fee Schedule Code.

Step	Adding a New Base Table to a Fee Schedule Procedures (continued)
5	Choose **OK** to create the new Base Table and attach it to the Fee Schedule.
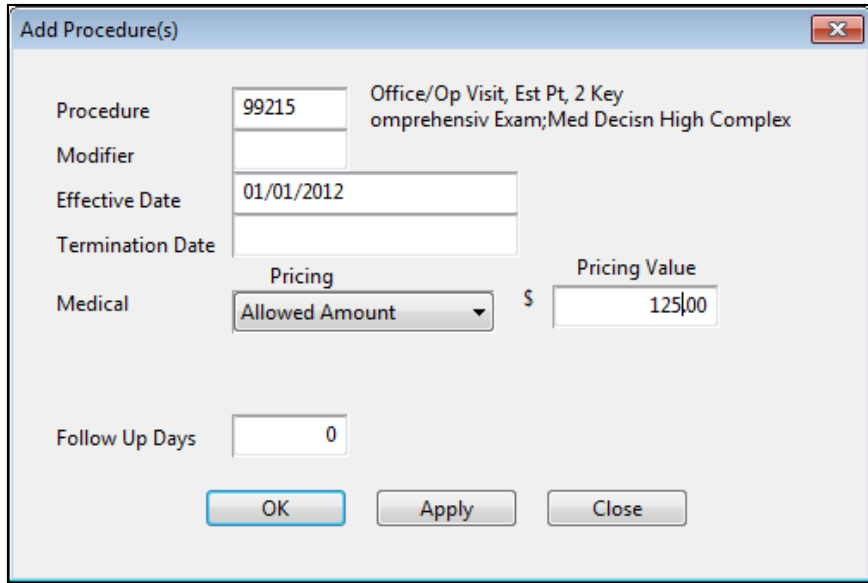
Populating a Base Table on a Fee Schedule

Step	Populating a Base Table on a Fee Schedule Procedures
1	To open the Base Table and enter values, highlight the Fee Schedule in the grid and open the "**Data**" section of the **Schedule Details** folder.
2	The Base Table opens. To view existing rows in the table, click the **Search** button.

Step	Populating a Base Table on a Fee Schedule Procedures (continued)
3	To add a row, select **Add** from the **Edit** menu (**Alt+E+A**).
4	The **Add Procedure** dialog box opens. Complete the required fields: **Procedure**, **Effective Date** and **Termination Date**. **Note**: If the **Termination Date** is left blank, a system-generated date of "12/31/9999" is inserted.

Step	Populating a Base Table on a Fee Schedule Procedures (continued)
5	A "Pricing Method" must be chosen to support the price.
6	Enter a Pricing Value. **Note**: A Pricing Value can be a percentage or an amount, depending on the Pricing Method selected. The selection of "By Report" requires no pricing value. The Pricing Value can be blank, but it will reflect '0' as a value.
7	Choose **OK** when finished entering values. The table now contains a pricing row for the Procedure code.
8	Repeat as needed.
9	When complete, choose **OK**. The Data section grid displays the **Schedule** and **Amounts**. The structure and values of the table will be saved.

OON-NetworX*Pricer* Term ID (NSRS)

When determining pricing, Facets will obtain a Service Definition type AGSE prefix, which is attached to the agreement. If no agreement is found, it will obtain the Service Definition type SEDF prefix, which is attached to the member's product. However, if NetworXPricer is used and no agreement is found to determine pricing (professional only), Facets will use the NSRS (OON NetworXPricer Term ID) prefix attached to the member's product. This prefix will be used to open a Medical Agreement Configurator record in order to determine Out-of-Network Professional Pricing.