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## Claims Data Models

### Objectives

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

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

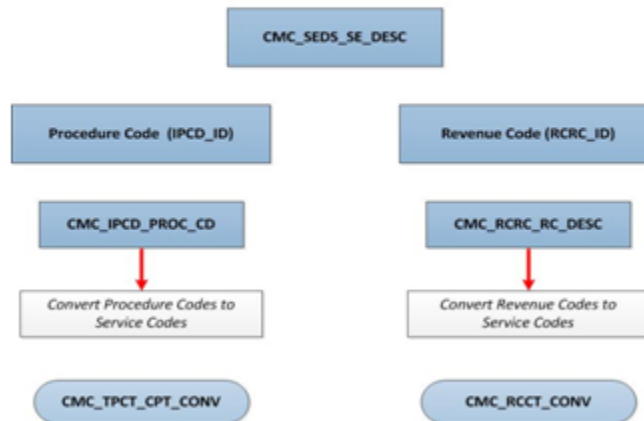


## Creating Service IDs

### Creating Service IDs



#### Defines Service IDs & Descriptions



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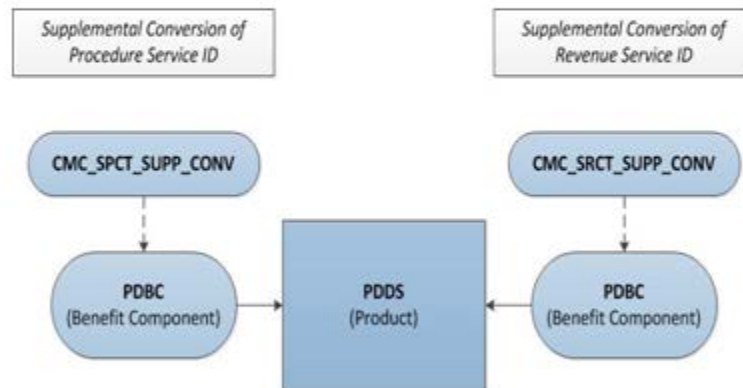
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Facets prices Procedure, Revenue, and HCPCS codes by converting each to a Service ID (SESE\_ID). Several tables support the storage of procedure codes, as well as the conversion process to a SESE\_ID.

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



## Creating Service IDs



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Service Codes (SESE\_ID) can convert to another Service Code within the **Supplemental Conversion** tables based on the member's age, gender, diagnosis, provider specialty, or provider type. Facets also identifies a patient relationship field, **SPCT\_RELATION**, on the **SPCT\_SUPP\_CONV** table.

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



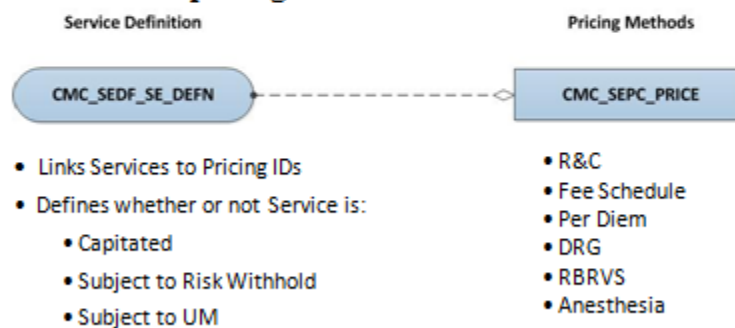


## Service Definition – Link to Facets Pricing

### Service Definition – Link to Facets Pricing



- ▶ For given **Service Definition**, one **Service Pricing Method** exists per service (**SESE\_ID**)
- ▶ For given **SESE\_ID**, a corresponding **SEPC\_PRICE\_ID** ties procedure to a pricing method



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

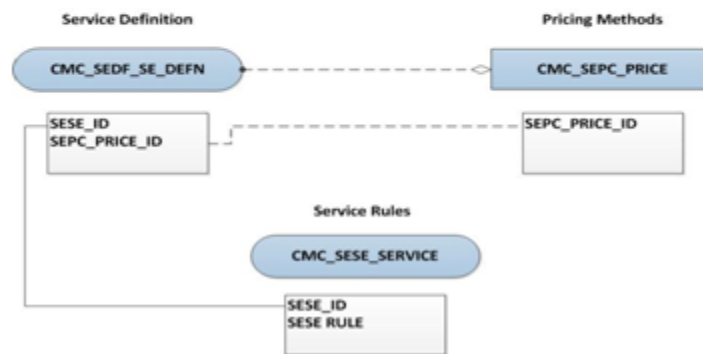


## Service Definition – Link Facets Pricing to Payment



### ► Service Rule Table Defines:

- The order Facets calculates copay, coinsurance, deductibles
- Valid gender & age ranges
- Amount or Counter oriented



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



## Facets Pricing

### *Facets Pricing*



#### ► Facets Tables involved in Pricing:

- CMC\_SEIP\_PFX:
  - Various prefixes created linking other pricing variables for payment
  - Types of pricing defined here
- SEIP\_TYPE\_PFX values point to other tables:
  - 1 = ZPCD - Zip Code Pricing Information
  - 2 = ZPRB - RBRVS Zip Code Table
  - 3 = IPRS - R&C/Schedule Pricing Table
  - 4 = IPRV - Unit Value Pricing Table
  - 5 = IPCF - Procedure Conversion Factor Pricing
  - 9 = IPTR - Procedure Tiers
- How do we find a price for a procedure that pays R & C?

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



## Facets Pricing



► **Prefixes determine pricing methodology Facets follows during claim adjudication:**

- For R&C pricing example: Step 1
  - Define and store Zip code type prefix in SEIP

### CMC\_SEIP\_PFX

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





## Pricing

### Pricing



#### ► For R&C pricing example: Step 2

- Define and store actual Zip code ranges in ZPCD

#### CMC\_ZPCD\_ZIP\_DATA

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

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## Facets Pricing

### *Facets Pricing*



#### ► For R&C pricing example: Step 3

- Define and store R&C type in SEIP (again)

#### CMC\_SEIP\_PFX

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



## Facets Pricing



### ► For R&C pricing example: Step 4

- Define and store \$ rate for procedure(s)

#### CMC\_ZPCD\_ZIP\_DATA

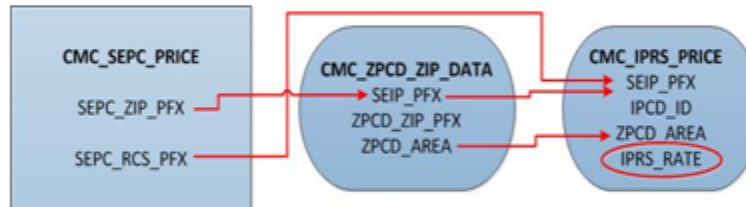
SEIP_PFX	01	01
IPCD_ID	99211	99211
ZPCD_AREA	001	002
IPRS_EFF_DT	01/01/2010	01/01/2010
IPRS_TERM_DT	12/31/9999	12/31/9999
IPRS_RATE	\$125	\$100
IPRS_DISC_PCT		
IPRS_LOCK_TOKEN		
IPRS_TERM_DT		



## Facets Pricing



- Tie it all together; see prefixes in **CMC\_SEPC\_PRICE** table:



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The **SEPC\_ZIP\_PFX** points to the **ZPCD** table, which determines the **ZPCD\_AREA** based on the provider's 3 digit zip code.

The **SEPC\_RCS\_PFX** points to the **IPRS** table, which determines the **SEIP\_PFX** to utilize during adjudication.

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



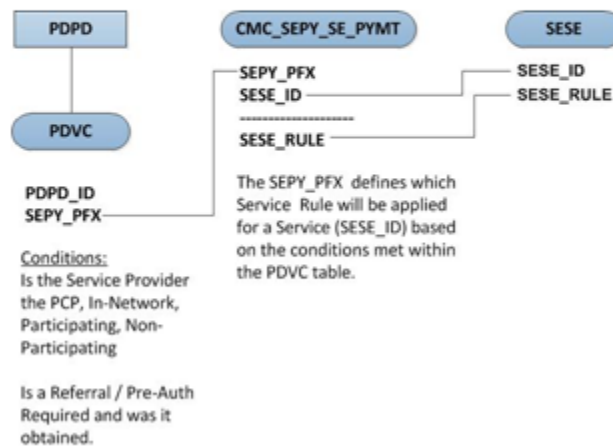


## Service Payment – Linking the Product

### Service Payment – Linking the Product



- **Locate Service Rule (SESE\_RULE) Facets uses to price a service (SESE\_ID) within a product**



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



## Claim Adjudication Sequence

### *Claim Adjudication Sequence*



#### **1. Eligibility:**

- ▶ **Is Subscriber/Member & Group a valid entity?**
  - CMC\_SBSB\_SUBSC
  - CMC\_GRGR\_GROUP
- ▶ **Does a Valid Class/Plan exist?**
  - CMC\_CSPI\_CS\_PLAN
- ▶ **Is member eligible?**
  - CMC\_MEPE\_PRCES\_ELIG

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

The 14 steps include:

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



## ***Claim Adjudication Sequence***



### **2. Provider/PCP/Network determination:**

- ▶ **Facets determines if servicing provider on claim is member's PCP:**
  - CMC\_MEPR\_PRIM\_PROV
- ▶ **Facets determines if servicing provider covers for PCP:**
  - CMC\_PRCV\_COV\_PRAC
- ▶ **Facets determines if servicing provider is secondary provider:**
  - CMC\_PRER\_RELATION
- ▶ **Identify the Provider/Network relationship:**
  - CMC\_NWST\_NET\_SET
  - CMC\_NWPR\_RELATION

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### 2. Provider/PCP/Network determination:

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



## Claim Adjudication Sequence



### 3. Service Definition (AGSE or SEDF):

#### ► If a Provider Agreement exists:

- Facets obtains Agreement record, link AGSE\_PFX to SEDF table:
  - CMC\_AGAG\_AGREEMENT
  - CMC\_SEDF\_SE\_DEFN

#### ► If a Provider Agreement does not exist:

- Obtain Product's Service Definition Benefit Component prefix, link to corresponding SEDF row:
  - CMC\_PDBC\_PROD\_COMP
  - CMC\_SEDF\_SE\_DEFN

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





## Claim Adjudication Sequence



### 4. Charges roll-up to one line for:

- ▶ All Inclusive Per Diem
- ▶ All Inclusive Per Case
- ▶ DRG pricing types

### 5. Duplicate Editing/Claims History check:

- ▶ CMC\_DUMD\_DUP\_EDIT - Medical Claim Duplicate Rules

### 6. Managed Care edits:

- ▶ Matching Referral/Pre-Authorization requirements:
  - CMC\_CLUM\_MATCH\_CR:
    - Match claim to UM requirements per parameters found in this table

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4. For All Inclusive Per Diem, All Inclusive Per Case, and DRG pricing types, charges roll up to one line (a room and board line for Per Diem and Per Case, and a \*RG line for DRG pricing).
  - Roll-up pricing does not add together the units on each line of the claim.
  - Roll-up pricing occurs on services with the same date of service.
  - Roll-up pricing does not apply to services specifically excluded, as defined on the Exclusions application.
- Roll-up pricing does not override external pricing.
5. Facets checks for duplicate claim lines on the current claim and claims in history using the Duplicate Claims Rules, Medical record (CMC\_DUMD\_DUP\_EDIT).
6. The Claims Processing applications convert the Procedure or Revenue Code to a Type of Service. Facets then uses the claim's servicing provider or Facility ID, procedure code, type of service, and diagnosis code to determine whether or not the referral and/or pre-authorization requirements exist for the claim's line item(s). If the servicing provider or facility's **Pre-authorization Required** field on the Practitioner or Facility record populates with (continued):



**continued...**

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

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

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

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

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

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



## Claim Adjudication Sequence



### 7. Clinical Editing:

#### ► Administrative Rules:

- CMC\_EAPE\_PROC\_EDIT - Rules
- CMC\_EAAR\_ADM\_RULES - Rules
- CMC\_EAIP\_IPCD - Rules

#### ► Criteria Tables:

- CMC\_CEIP\_REL\_CRIT - Procedure Editing Criteria
- CMC\_CECE\_CRITERIA - Procedure Appropriateness Criteria
- CMC\_CEID\_REL\_ID - Procedure/Diagnosis Mapping

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



## Claim Adjudication Sequence



### 8. Line Item Prefixes:

- ▶ CMC\_CDML\_CL\_LINE
- ▶ CMC\_CDDL\_CL\_LINE

### 9. Pricing (SEPC for Facets pricing, AGSE for NetworX pricing):

- ▶ CMC\_SESE\_SERVICE
- ▶ CMC\_SEDF\_SE\_DEFN

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





## ***Claim Adjudication Sequence***



### **10. Service Rules, Deductibles, Limits, Penalties:**

- ▶ **CMC\_LTLT\_LIMIT - Limit Prefixes and Accumulators\**
- ▶ **CMC\_DEDE\_DEDUCT - Deductible Prefixes and Accumulators**
- ▶ **CMC\_EBCL\_EOB\_DATE - The accumulators reported on EOB**

### **11. Apply COB:**

- ▶ **Rules for calculating COB:**
  - **CMC\_CBCB\_COB - Calculation Method**
  - **CMC\_CBSE\_COB\_IX - Service Exclusions**

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10. Service rules help Facets adjudicate payment based on several parameters. A user may apply multiple service rules (SESE\_RULES) to a Service ID (SESE\_ID). A Service Rule establishes the calculation method of the service, any claims processing edits, penalty types and amounts, and service tiers. At a high level, Facets determines how services price:

- Will Medical claims price by reasonable and customary (R&C) rates or fee schedules?
- Will Room and Board services reimburse by Per Diem/Per Case or DRG rates?

11. Users select a calculation method from a variety of options in order to administer COB provisions properly. One product can require COB to coordinate up to the higher of the two carriers allowable amounts, while another product administered by the same carrier, can require coordination to their own (i.e., Facets) allowable amount or even the submitted charges on the claim.



## ***Claim Adjudication Sequence***



### **12. Payment Drag:**

▶ **CMC\_AIAI\_ADM\_INFO OR CMC\_AGAG\_AGREEMNT**

### **13. Accumulator Update:**

▶ **CMC\_MEAC\_ACCUM**

▶ **CMC\_FAAC\_ACCUM**

### **14. Claim Status updated:**

▶ **01 - Claim awaiting batch**

▶ **15 – Claim pends with error**

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12. Payment Drag alters the timing of when a provider's claim runs through the claims payment batch. Payment Drag at the agreement level supersedes Payment Drag at the Administrative Information level found on the Product.

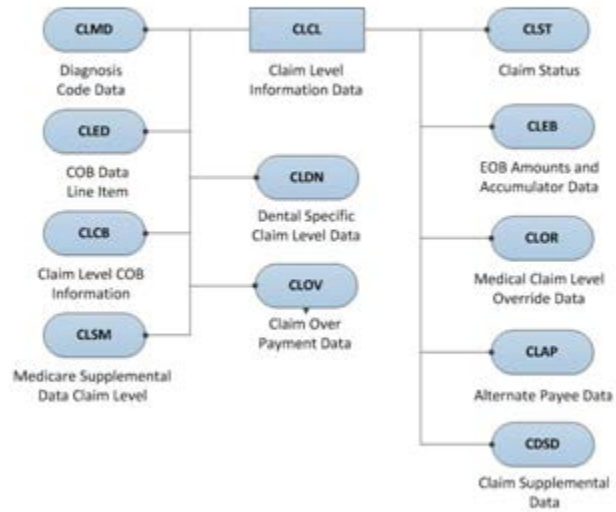
13. Accumulators allow MCOs to do the following:

- Track benefits by either money or number of visits (counter).
- Track benefits at the member or family level.
- Identify accumulator buckets for all members of a specific product.
- Track accumulations by a specified amount of time (yearly or by lifetime).
- Track the amount of money spent or saved through Coordination of Benefits (COB).

14. Facets updates the status of the claim.



## Claim Summary Tables





## Claims Database – Claim Summary Table

### *Claims Database – Claim Summary Table*



#### ► **CMC\_CLCL\_CLAIM**

- Table Highlights:
  - Total Charges and Payable Amounts reflecting service line summary
  - Claim ID = CLCL\_ID, one row per Claim ID
  - Stores most recent claim status (CLCL\_CUR\_STS)
- Required Fields

CLCL\_ID  
 MEME\_CK  
 GRGR\_CK  
 SBSB\_CK  
 CLCL\_CL\_TYPE  
 CLCL\_CL\_SUB\_TYPE  
 CLCL\_CUR\_STS  
 CLCL\_SITE  
 CLCL\_LAST\_ACT\_DTM  
 CLCL\_INPUT\_DT  
 CLCL\_REC'D\_DT  
 CLCL\_ACPT\_DT  
 CLCL\_LOW\_SVC\_DT  
 CLCL\_HIGH\_SVC\_DT

...continued

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





**continued...**

CSPD\_CAT

CSCS\_ID

CSPI\_ID

PDPD\_ID

MEPE\_FI

MEPE\_PLAN\_ENTRY\_DT

CLCL\_COBRA\_IND

CLCL\_ME\_AGE

MEME\_REL

MEME\_SEX

MEME-RECORD\_NO

PDBC\_PFX\_SEDF





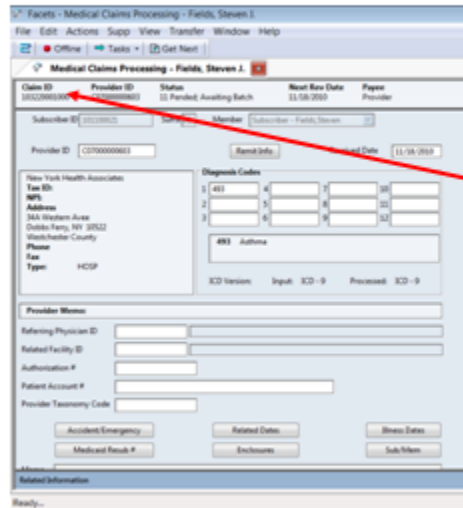


**continued...**

CLCL\_LAST\_ACT\_DTM: datetime  
CLCL\_INPUT\_DT: datetime  
CLCL\_RECD\_DT: datetime  
CLCL\_ACPT\_DTM: datetime  
CLCL\_PAID\_DT: datetime  
CLCL\_NEXT\_REV\_DT: datetime  
CLCL\_LOW\_SVC\_DT: datetime  
CLCL\_HIGH\_SVC\_DT: datetime  
CLCL\_ID\_ADJ\_TO: char(12)  
CLCL\_ID\_ADJ\_FROM: char(12)  
CLCL\_ID\_CRTE\_FROM: char(12)  
CSPD\_CAT: char(1)  
PZAP\_ID: char(4)  
CSCS\_ID: char(4)  
CSPI\_ID: char(8)  
PDPD\_ID: char(8)  
MEPE\_FI: char(1)  
MEPE\_PLAN\_ENTRY\_DT: datetime  
CLCL\_COBRA\_IND: char(1)  
CLCL\_ME\_AGE: smallint  
MEME\_REL: char(01)  
MEME\_SEX: char(1)  
MEME\_RECORD\_NO: char(11)  
MEME\_HICN: char(12)



## Claims Summary Table – CMC\_CLCL\_CLAIM

CLCL\_ID: char(12)

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





## Claims Summary Table – CMC\_CLCL\_CLAIM




The screenshot shows the 'Medical Claims Processing - Fields, Steven J.' window. It displays a claim summary for a vision claim. Key fields include:

- Claim ID:** 181220000000
- Provider ID:** 037000000000
- Status:** 11 Pending: Awaiting Batch
- Next Rev Date:** 11/18/2009
- Pages:** 1
- Total Charge:** \$200.00
- Patient Paid:** \$0.00
- From:** 11/10/2009
- To:** 11/10/2009
- POS:** 32
- SN:** V0
- Proc:** 98253
- Diagnosis:** 400
- Charges:** \$200.00
- Units:** 1
- Accident/Emergency:** No
- Date of Current Service:** 09/01/2009
- Medical Records #:** No
- Outside Lab:** No
- COB Status:** No
- Assignment of Benefits:** No
- External Referral:** No
- External Referral Number:** No
- Medical Records No.:** No

CLCL\_CL\_TYPE: char(1)

CLCL\_CL\_SUB\_TYPE:  
char(1)

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

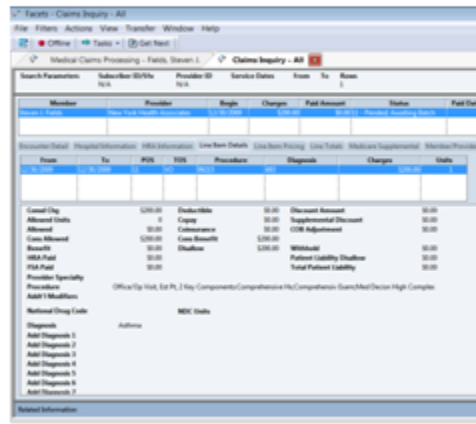
- M – Medical
- D – Dental
- V - Vision
- F – FSA
- E – Encounter
- R – Reimbursable

The CLCL\_CL\_SUB\_TYPE indicates the level below the claim type. Values include:

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



## Claims Summary Table – CMC\_CLCL\_CLAIM

CLCL\_PRE\_PRICE\_IND:  
char(1)

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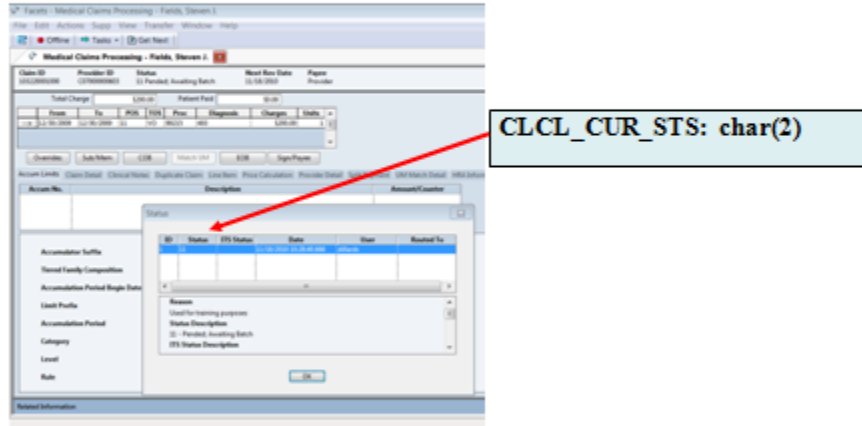
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The CLCL\_PRE\_PRICE\_IND indicates if a claim pre-priced and adjudicated, pre-priced only, or adjudicated only. Values include:

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



## Claims Summary Table – CMC\_CLCL\_CLAIM

The screenshot shows the 'Medical Claims Processing - Fields, Screen 1' window. It contains various fields for claim processing, including 'Claim ID', 'Provider ID', 'Status', 'Next Due Date', and 'Payment'. A table titled 'Account Lines' is visible, with columns for 'ID', 'Status', 'Rate', 'Year', and 'Amount'. A red arrow points from a text box labeled 'CLCL\_CUR\_STS: char(2)' to the 'Status' column in this table.

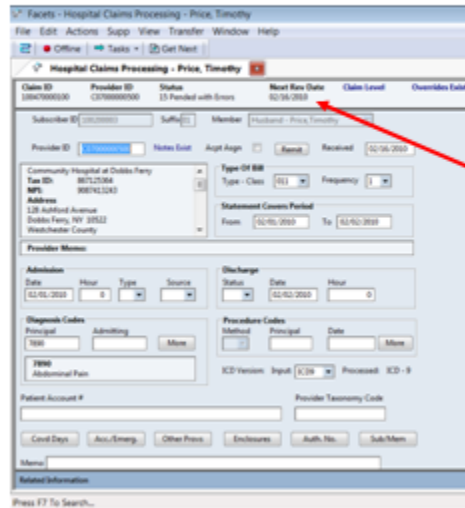
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The system generated code, CLCL\_CUR\_STS, identifies the current status of the claim. A total of 12 values complete this column, such as 01 - Claim Accepted; Awaiting Batch.



## Claims Summary Table – CMC\_CLCL\_CLAIM

The screenshot shows the 'Hospital Claims Processing - Price, Timorly' application window. The window has a menu bar (File, Edit, Actions, Supp, View, Transfer, Window, Help) and a toolbar (Offline, Tasks, Get Next). The main area contains a form with various fields for claim processing. A red arrow points from the 'CLCL\_NEXT\_REV\_DT: datetime' text box to the 'Next Review Date' field in the 'Hospital Claims Processing - Price, Timorly' window.

**CLCL\_NEXT\_REV\_DT:**  
datetime

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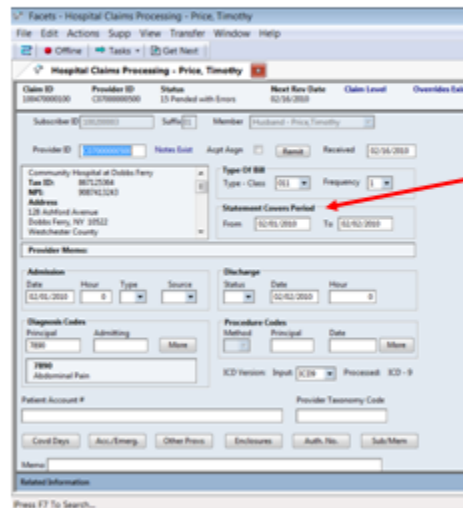
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CLCL\_NEXT\_REV\_DT indicates the next review date of a pended claim (status 11) and is required if the claim is pended.





## Claims Summary Table – CMC\_CLCL\_CLAIM

**CLCL\_LOW\_SVC\_DT:**  
datetime

Dates of Service span

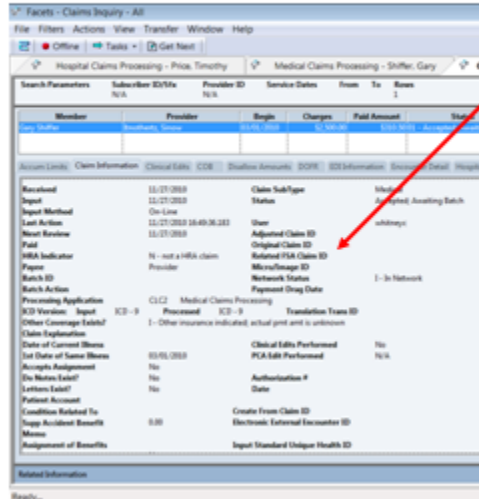
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The CLCL\_LOW\_SVC\_DT and the CLCL\_HIGH\_SVC\_DT provide the range of dates for this claim.



## Claims Summary Table – CMC\_CLCL\_CLAIM

Facets - Claims Inquiry - All

File: Filters Actions View Transfer Window Help

Offline Tasks Get Next

Hospital Claims Processing - Price, Timothy Medical Claims Processing - Shifter, Gary

Search Parameters: Subscriber ID: N/A, Provider ID: N/A, Service Dates: From: To: Rows: 1

Member	Provider	Begin	Charges	Paid Amount	Status
John Smith	Smith, John	11/11/2013	10,000.00	10,000.00	Approved

Accounts: Claims Information Clinical Data CDR Shadow Accounts DPM Billing Information Services Detail Hospital

Received	11/11/2013	Claim SubType	Medical
Input	11/11/2013	Status	Approved, Awaiting Batch
Input Method	On-Line		
Last Action	11/11/2013 16:40:36.383	User	admin@...
Next Review	11/11/2013	Adjusted Claim ID	
Paid		Original Claim ID	
IRB Indicator	NI - not a HRA claim	Related ISA Claim ID	
Payer	Provider	MicroImage ID	
Batch ID		Network Status	1-In Network
Batch Action		Payment Using Date	
Processing Application	CLC2 Medical Claims Processing		
ICD Version	Input: ICD-9, Processed: ICD-9	Translation From ID	
Other Coverage Excluded	1 - Other insurance indicated, actual amt sent is unknown		
Claim Explanation			
Date of Current Review		Clinical Edit Performed	No
Set Date of Future Review	11/11/2013	PLA Edit Performed	N/A
Accruals Assignment	No		
Do Status Exist?	No	Authorization #	
Letters Exist?	No	Date	
Patient Account			
Condition Related To		Create From Claim ID	
Group Accident Benefits	0.00	Electronic External Encounter ID	
Member			
Assignment of Benefits		Input Standard Unique Health ID	

Related Information

Ready...

22

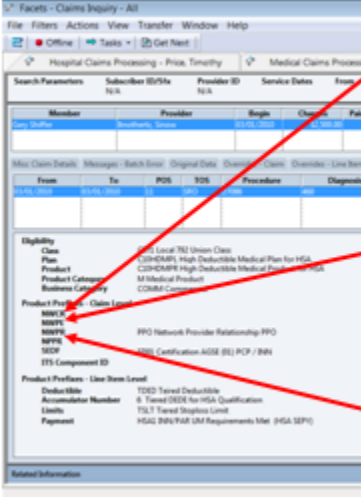
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The system generated entry of CLCL\_ID\_ADJ\_TO includes the 10 position base claim number as the CLCL\_ID plus the 2 position segment, which varies.

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



## Claims Summary Table – CMC\_CLCL\_CLAIM

**NWCR\_PFX: char(4)**

**NWPE\_PFX: char(4)**

**NWPR\_PFX: char(4)**

Facets - Claims Inquiry - All  
File Filters Actions View Transfer Window Help  
Offline Tasks Get Next  
Hospital Claims Processing - Price, Timeliness Medical Claims Process  
Search Parameters Subscriber ID/PA# Provider ID Service Dates From To  
Member Provider Single Check PA#  
Line Number Description Date of Service Date of Bill  
Misc Claim Details Messages Batch Error Original Date Original Date Claim Overrides Line Item  
From To POS POS Procedure Diagnosis  
Eligibility  
Class Local TEL Union Class  
Plan C29-HDMP High Deductible Medical Plan for HSA  
Product C29-HDMP High Deductible Medical Product for HSA  
Product Category M Medical Product  
Business Category C29-HDMP  
Product Profiles - Line Item Level  
NWCR PPO Network Provider Relationship PPO  
NWPE PPO Network Provider Relationship PPO  
NWPR PPO Network Provider Relationship PPO  
NDCP Certification AGS (S) PCP / BBA  
ITS Component ID  
Product Profiles - Line Item Level  
Deductible TDED TDED Deductible  
Accumulator Number 6 TDED/AGS Non-HSA Qualification  
Limits TDED TDED Stoploss Limit  
Payment HSA/BNP/AM Requirements Note (HSA SEP)

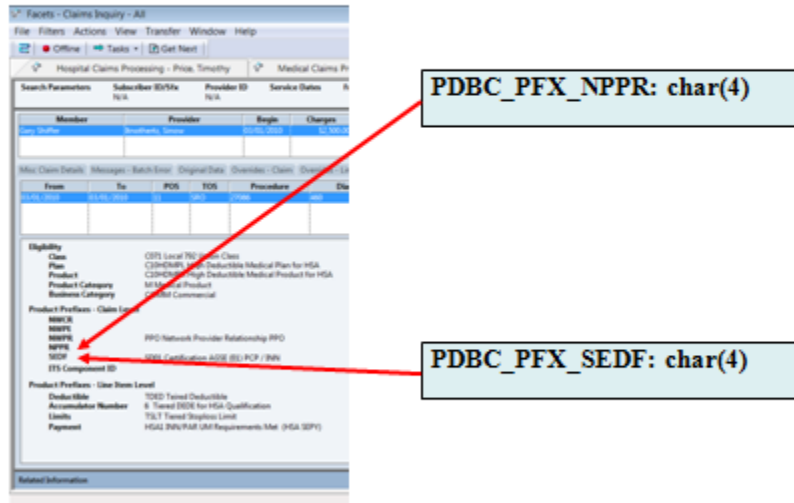
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The NWPE\_PFX, NWCR\_PFX, and the NWPR\_PFX identify the Network Provider Capitation Relationship prefix used in adjudicating this claim.



## Claims Summary Table – CMC\_CLCL\_CLAIM

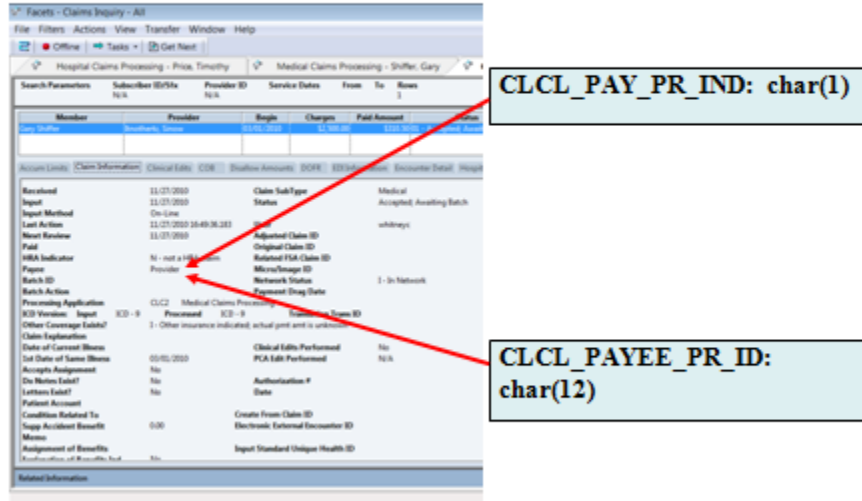
The screenshot shows the 'Facets - Claims Inquiry - All' window. The 'Claims Summary Table' is visible, with columns for 'From', 'To', 'POS', 'EOS', 'Procedure', and 'Rate'. Two red arrows point from the table to callout boxes. The first arrow points to the 'PDBC\_PFX\_NPPR' field, which is labeled 'PDBC\_PFX\_NPPR: char(4)'. The second arrow points to the 'PDBC\_PFX\_SEDF' field, which is labeled 'PDBC\_PFX\_SEDF: char(4)'.

The PDBC\_PFX\_NPPR and PDBC\_PFX\_SEDF identify the non-participating provider relationship and Service Definition prefixes used in adjudication.





## Claims Summary Table – CMC\_CLCL\_CLAIM

Facets - Claims Inquiry - All

File: Filters Actions View Transfer Window Help

Search Parameters: Subscriber ID/SA: N/A Provider ID: N/A Service Dates: From: To: Rows: 1

Member: [Name] Provider: [Name] Begin: [Date] Charges: [Amount] Paid Amount: [Amount]

CLCL\_PAY\_PR\_IND: char(1)

CLCL\_PAYEE\_PR\_ID: char(12)

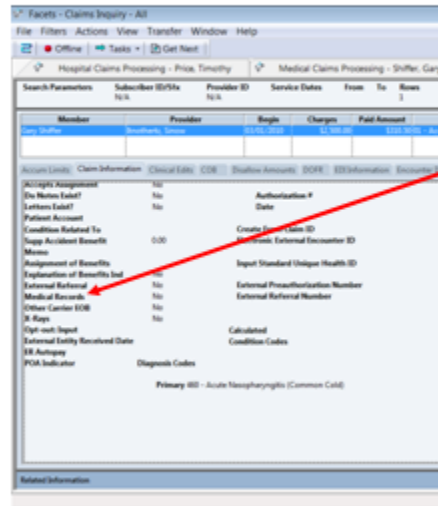
22

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



## Claims Summary Table – CMC\_CLCL\_CLAIM

**CLCL\_REL\_INFO\_IND:**  
char(1)

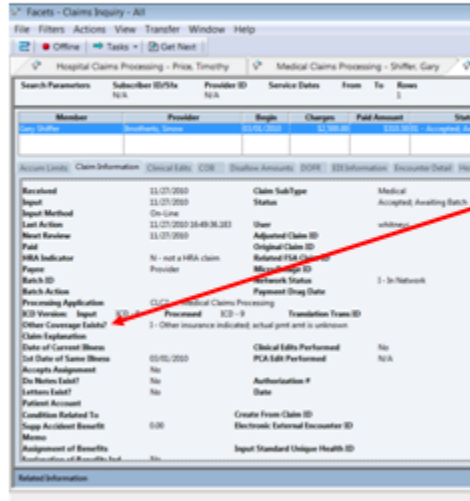
29

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



## Claims Summary Table – CMC\_CLCL\_CLAIM

**CLCL\_OTHER\_BN\_IND:**  
**char(1)**

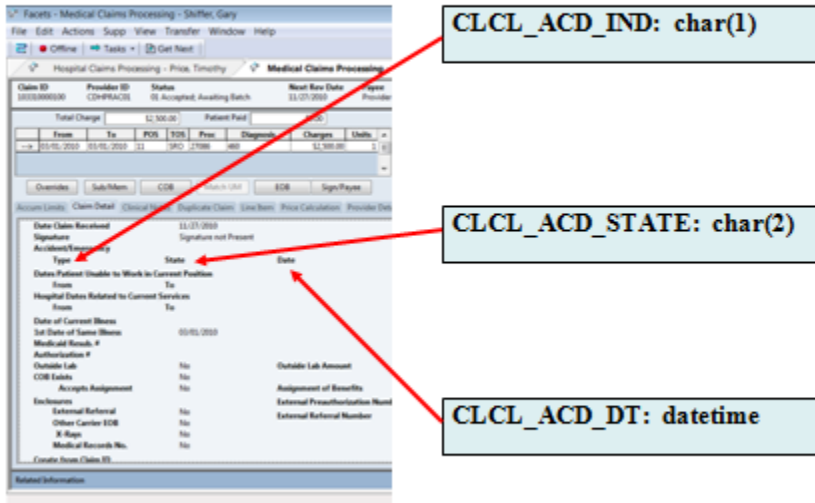
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Indicator	Meaning
CLCL_OTHER_BN_IND	This indicates if other benefits apply to this claim only.
I	This indicates other insurance; the actual payment amount is unknown.
N	No
Y	Yes
U	This indicates other reported insurance; info gets sent.

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



## Claims Summary Table – CMC\_CLCL\_CLAIM

**CLCL\_ACD\_IND: char(1)**

**CLCL\_ACD\_STATE: char(2)**

**CLCL\_ACD\_DT: datetime**

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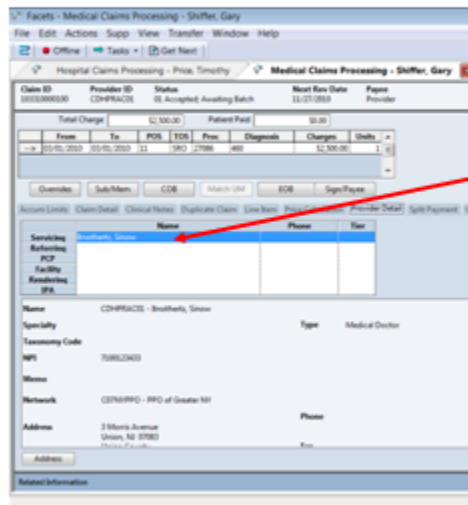
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Type	Meaning
CLCL_ACD_IND	This identifies whether the claim relates to an accident or emergency illness.
CLCL_ACD_STATE	This identifies if this claim relates to an automobile accident. If so, select the state in which the accident occurred. Facets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





## Claims Summary Table – CMC\_CLCL\_CLAIM

Facets - Medical Claims Processing - Shiffer, Gary

File Edit Actions Supp View Transfer Window Help

Offline Tasks Get Next

Hospital Claims Processing - Price, Timothy Medical Claims Processing - Shiffer, Gary

Claim ID: 0000000000 Provider ID: CDMRAC00 Status: 00 Accepted/Waiting Batch Next Rele Date: 11/01/2009 Paper: Provider

Total Charge: \$2,500.00 Patient Paid: \$0.00

From	To	POS	TDR	Proc	Diagnosis	Charge	Units
10/01/2009	10/01/2009	22	1800	17999	400	\$2,500.00	1

Overrides Sub/Item CDB Match/UB EOB Sign/Print

Account Links: Claim Detail Clinical Notes Duplicate Claim Line Item Bill/Invoice Provider Detail Split Payment UM

	Name	Phone	Fax
Servicing			
Referring			
PCP			
Referring			
IPR			

Name: CDMRAC00 - Smith, Simon Type: Medical Doctor

Specialty:

License Code:

NPI: 708025400

Network: CDMRAC00 - PPO of Greater MI

Address: 210000 Avenue, Detroit, MI 48203 Phone:

Address:

Related Information:

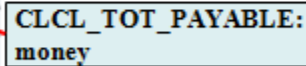
PRPR\_ID: char(12)

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Type	Meaning
PRPR_ID	Identifies the Servicing Provider of the claim, which must be a valid PRPR_ID on the <b>PRPR</b> table.







## Claim Line Item Details

### *Claim Line Item Details*



**Claim Line Items tables are dependent on  
CLCL\_CL\_SUB\_TYPE**

► **3 subtypes for claims:**

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

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- For Medical claims, (CLCL\_CL\_TYPE=M and CLCL\_CL\_SUB\_TYPE=M or H) use CMC\_CDML\_CL\_LINE.
- For UB04 Hospital claims, (CLCL\_CL\_TYPE=M and CLCL\_CL\_SUB\_TYPE=H) use CMC\_CLHP\_HOSP.



## ***Claim Line Item Details***



### **► Line Items for Medical claims include:**

- Service dates
- Place of service (POS)
- Type of service (TOS)
- Provider ID (PRPR\_ID)
- Diagnosis code (IDCD\_ID) fields expanded for ICD10 values
- Procedure code (IPCD\_ID) fields expanded for ICD10 values
- Service ID (SESE\_ID)
- Service Rule (SESE\_RULE)





### ***Claim Line Item Details***



---

► **Line Items for UB04 Hospital claims include:**

- Bill Class Type (CLHP\_BILL\_CLASS)
- Frequency code (CLHP\_FREQUENCY)
- Admission date (CLHP\_ADM\_DT)
- Admitting Provider ID (CLHP\_PRPR\_ID\_ADM)
- Procedure code (CLHP\_IPCD\_METH)



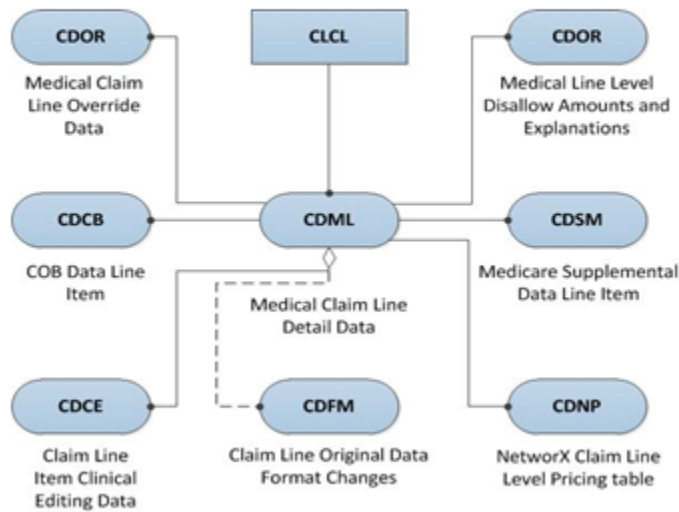
This table links to four other tables that supply additional information. They include:

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



## Medical Claims

### Medical Claims



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This displays the structure of the claim line, CMC\_CDML\_CL\_LINE, with its seven supporting tables:

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



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





## Medical Claim Line Item – CMC\_CDML\_CL\_LINE

### *Medical Claim Line Item – CMC\_CDML\_CL\_LINE*



#### Required Fields:

▶ CLCL_ID	▶ SESE_RULE
▶ CDML_SEQ_NO	▶ PSCD_ID
▶ MEME_CHK	▶ IDCD_ID
▶ PRPR_ID	▶ IDCD_ID_REL
▶ LOBD_ID	▶ CDML_FROM_DT
▶ PDVC_LOBD_PTR	▶ CDML_TO_DT
▶ CDML_CUR_STS	▶ CDML_CHG_AMT
▶ SEPC_PRICE_ID	▶ CDML_CONSIDER_CHG
▶ SESE_ID	...continued

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



***Medical Claim Line Item –  
CMC\_CDML\_CL\_LINE***



**Required Fields – continued...**

- |                           |                           |
|---------------------------|---------------------------|
| ▶ <b>CDML_ALLOW</b>       | ▶ <b>CDML_AG_PRICE</b>    |
| ▶ <b>CDML_UNITS_ALLOW</b> | ▶ <b>CDML_PF_PRICE</b>    |
| ▶ <b>CDML_DED_AMT</b>     | ▶ <b>CDML_IP_PRICE</b>    |
| ▶ <b>CDML_DED_ACC_NO</b>  | ▶ <b>CDML_SE_PRICE</b>    |
| ▶ <b>CDML_COPAY_AMT</b>   | ▶ <b>CDML_CL_NTWK_IND</b> |
| ▶ <b>CDML_COINS_AMT</b>   | ▶ <b>CDML_REF_IND</b>     |
| ▶ <b>CDML_RISK_WH_AMT</b> | ▶ <b>CDML_PC_IND</b>      |
| ▶ <b>CDML_PAID_AMT</b>    | ▶ <b>CDML_CAP_IND</b>     |
| ▶ <b>CDML_DISALL_AMT</b>  |                           |







**continued...**

RCRC\_ID: char(4)

SESE\_ID: char(4)

SESE\_RULE: char(3)

PSCD\_ID: char(2)

IPCD\_ID: char(7)

IDCD\_ID: varchar(10)

IDCD\_ID\_REL: varchar(10)

CDML\_FROM\_DT: datetime

CDML\_TO\_DT: datetime

CDML\_ROOM\_TYPE: char(2)

CDML\_CHG\_AMT: money

CDML\_ANES\_PHY\_STAT: char(1)

CDML\_HCPCS\_AMT: money

CDML\_CONSIDER\_CHG: money

CDML\_ALLOW: money

CDML\_UNITS: smallint

CDML\_UNITS\_ALLOW: smallint

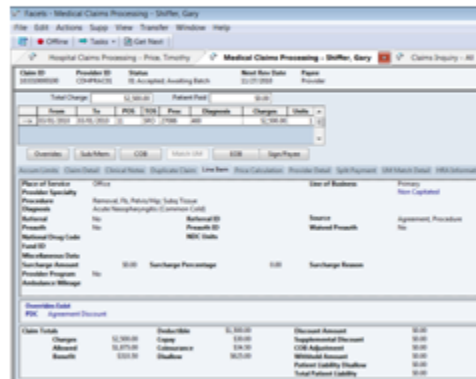
CDML\_DED\_AMT: money

CDML\_DED\_ACC\_NO: smallint





## Medical Claim Line Item – CMC\_CDML\_CL\_LINE

CDML\_SEQ\_NO: smallint

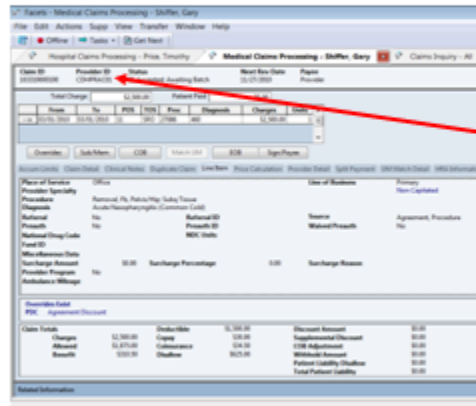
24

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



## Medical Claim Line Item – CMC\_CDML\_CL\_LINE

The screenshot shows a web application window titled "Medical Claims Processing - Staffer Query". It contains a table with columns: Line Item, Provider ID, Patient ID, Date of Service, Amount, and Charges. A red arrow points from the "Provider ID" column to a callout box.

**PRPR\_ID: char(12)**

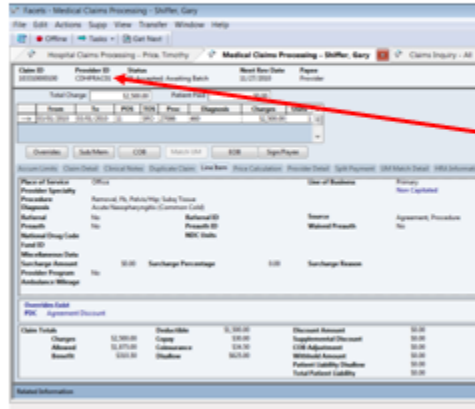
22

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



## Medical Claim Line Item – CMC\_CDML\_CL\_LINE

LOBD\_ID: char(4)

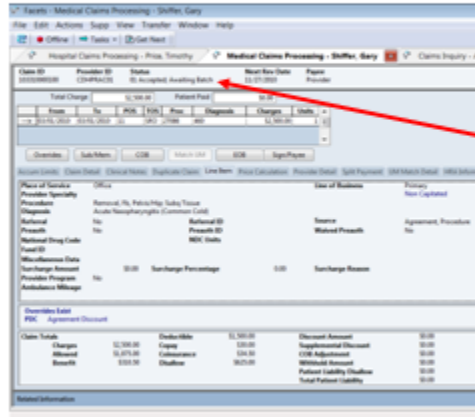
28

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



## Medical Claim Line Item – CMC\_CDML\_CL\_LINE

CDML\_CUR\_STS: char(2)

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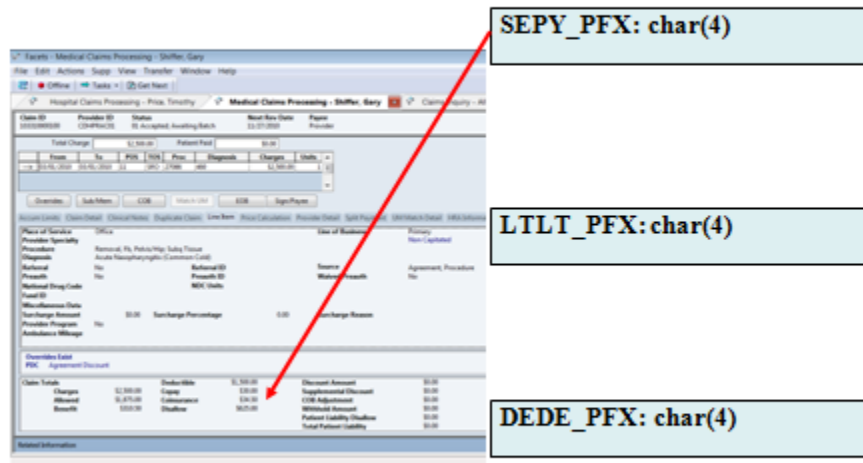
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Type	Meaning
CDML_CUR_STS	This indicates the current status of the claim, the same status as the <b>CLCL</b> table.





## Medical Claim Line Item – CMC\_CDML\_CL\_LINE

**SEPY\_PFX: char(4)**

**LTLT\_PFX: char(4)**

**DEDE\_PFX: char(4)**

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



**Medical Claim Line Item –  
CMC\_CDML\_CL\_LINE**

[illegible]

SEPC\_PRICE\_ID: char(4)

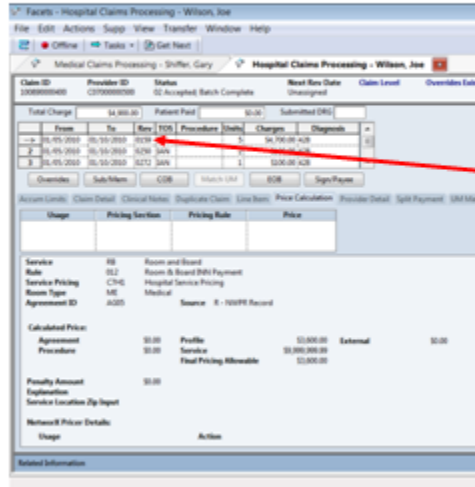
38

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



## Medical Claim Line Item – CMC\_CDML\_CL\_LINE

RCRC\_ID: char(4)

4 character code

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

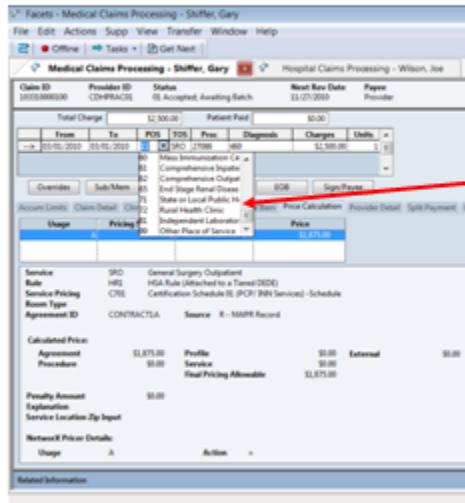


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## Medical Claim Line Item – CMC\_CDML\_CL\_LINE

PSCD\_ID: char(2)

(see dropdown options)

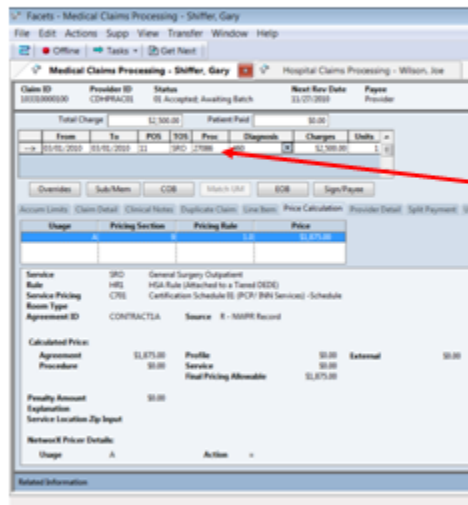
22

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



## Medical Claim Line Item – CMC\_CDML\_CL\_LINE

IPCD\_ID: char(7)

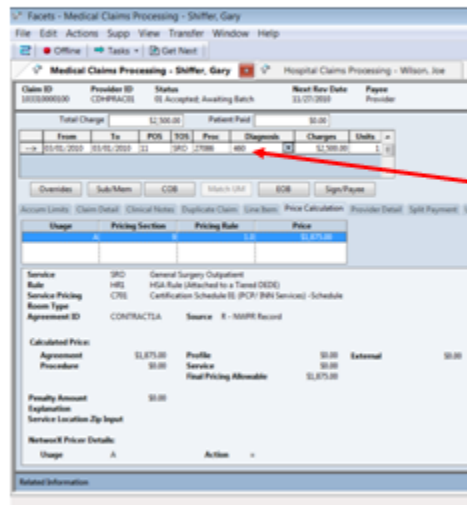
23

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



## Medical Claim Line Item – CMC\_CDML\_CL\_LINE

Facets - Medical Claims Processing - Shiffer, Gary

File Edit Actions Supp View Transfer Window Help

Medical Claims Processing - Shiffer, Gary Hospital Claims Processing - Wilson, Joe

Claim ID: 10101000100 Provider ID: CDMFAC01 Status: RL Accepted: Awaiting Batch Next Rev Date: 11/01/2008 Paper: Provider

Total Charge: \$2,100.00 Patient Paid: \$0.00

From	To	POL	QTY	Proc	Diagnosis	Charge	Units
11/01/2008	11/01/2008	11	1	SPD	450	\$2,100.00	1

Overrides Sub Menu CDR Which Line EOB Sign/Payee

Account Limits Claim Detail Clinical Notes Duplicate Claim Line Item Price Calculation Provider Detail Split Payment US

Charge	Pricing Section	Pricing Rule	Price
			\$2,100.00

Service: SPD General Surgery Outpatient  
 Rule: HFE HSA Rule (Attached to a Target OEDS)  
 Service Pricing: CDR Certification Schedule (R-PCP-999 Services) - Schedule  
 Room Type: CONTRACTA Source: R-MDR Record

Calculated Price:  
 Agreement: \$1,875.00 Profile: \$0.00 External: \$0.00  
 Procedure: \$0.00 Service: \$0.00  
 Final Pricing Allowable: \$1,875.00

Penalty Amount: \$0.00  
 Explanation: Service Location Zip Input

Network/Plan Pricing Details:  
 Charge: A Action: X

Related Information

**IDCD\_ID: varchar(10)**

(see dropdown options)

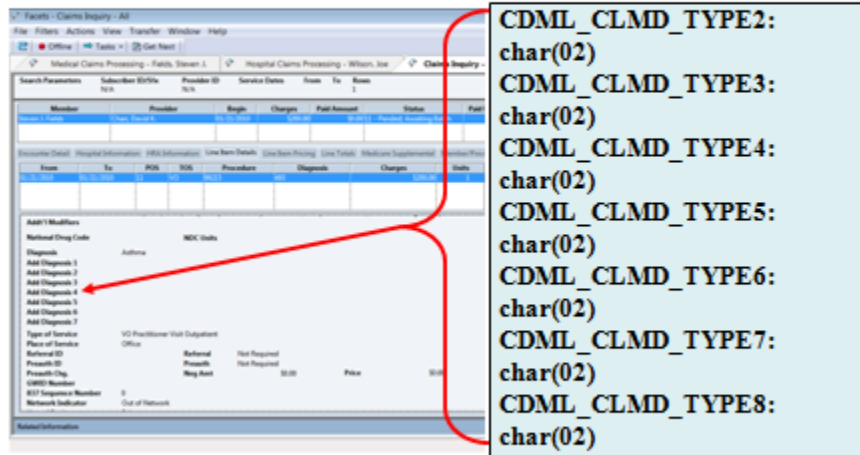
24

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



## Medical Claim Line Item – CMC\_CDML\_CL\_LINE

CDML\_CLMD\_TYPE2:  
char(02)

CDML\_CLMD\_TYPE3:  
char(02)

CDML\_CLMD\_TYPE4:  
char(02)

CDML\_CLMD\_TYPE5:  
char(02)

CDML\_CLMD\_TYPE6:  
char(02)

CDML\_CLMD\_TYPE7:  
char(02)

CDML\_CLMD\_TYPE8:  
char(02)

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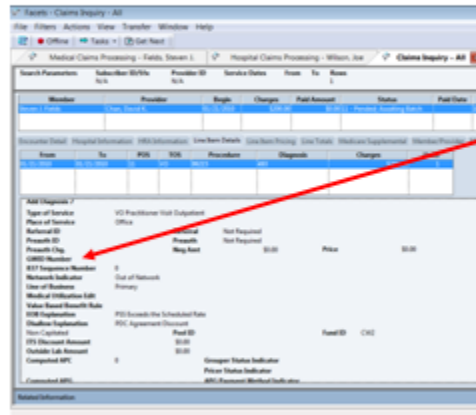
The 26 pointers that correspond to additional line item diagnoses include the following values:

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





## Medical Claim Line Item – CMC\_CDML\_CL\_LINE

The screenshot shows a 'Claims Inquiry - All' window. It contains several tabs and a main form area. The 'CDML\_GWID' field is located in the 'Add Charges of' section, specifically under the 'Medical Information' tab. A red arrow points from this field to a text box on the right.

**CDML\_GWID: varchar(32)**

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



**Medical Claim Line Item –  
CMC\_CDML\_CL\_LINE**

[illegible]

CDML_TOT_PA_LIAB:	money
-------------------	-------

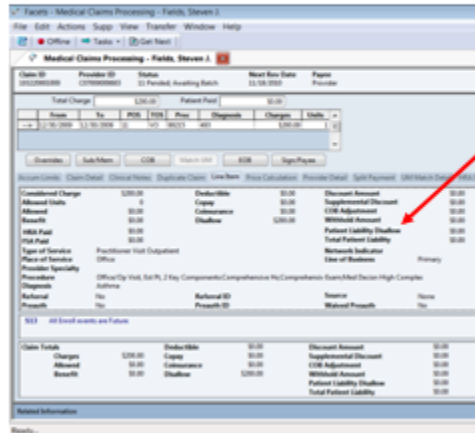
67

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



## Medical Claim Line Item – CMC\_CDML\_CL\_LINE

CDML\_DIS\_PA\_LIAB: money

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



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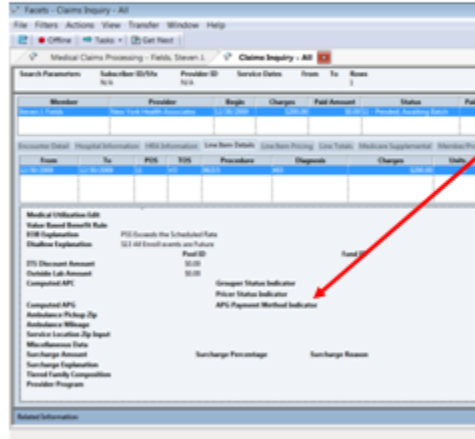








## Claims Tables - CMC\_CDSD\_SUPP\_DATA

**EAPM\_PAY\_METH\_IND:**  
**char(2)**

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







## Additional Diagnosis codes

### *Additional Diagnosis codes*



#### **5010 mandates additional diagnosis codes for Medical and Hospital**

##### ► **Medical:**

- 4 additional claim level diagnosis codes; 12 total

##### ► **Hospital:**

- 9 additional External Cause of Injury Codes; 12 total
- 7 additional Other Codes; 12 total
- 41 total diagnosis codes:
  - 1 - Principal
  - 1 - Admitting
  - 3 - Patient Reason for Visit
  - 12 - External Cause of Injury
  - 24 - Other





## Claim Adjustments: Underpayment

### Claim Adjustments: Underpayment



CLCL			
Claim Id	Status	Paid Amt	Claim ID Adjusted To / From
111111111100	01, 02, 91	\$50	To: 111111111101
111111111101	01, 02	\$100	From: 111111111100

CDML			
Claim Id	Line	Status	Paid Amt
111111111100	1	01, 02, 91	\$25
111111111100	2	01, 02, 91	\$25
111111111101	1	01, 02	\$75
111111111101	2	01, 02	\$25

CLST	
Claim Id	Status
111111111100	01
111111111100	02
111111111100	91
111111111101	01
111111111101	02

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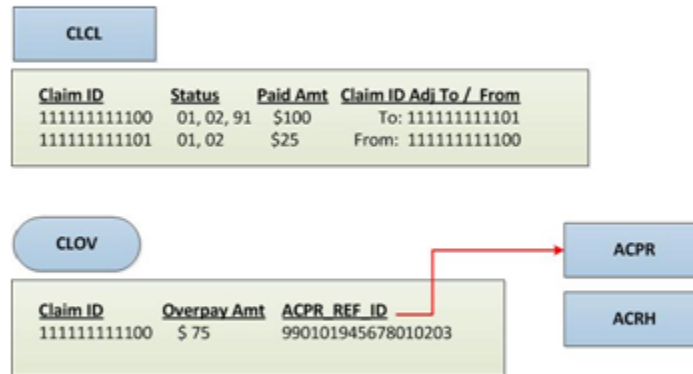
Facets contains two types of adjustments; overpayment and underpayment. This slide represents the underpayment adjustment. The first line displays the original claim that paid \$50. Due to some change or review, Facets determined that not enough money was paid for the services under this claim. On the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

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



## Claim Adjustments: Overpayment

### *Claim Adjustments: Overpayment*



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

This creates a row on the **CMC\_CLOV\_OVERPAY** table, which holds a reference to the **Accounting** table, **CMC\_ACPR\_PYMT\_RED**. This table tracks the reduction of the overpayment on subsequent claims. The **CMC\_ACRH\_RED\_HIST** table holds the amount deducted from each claim until the overpayment gets satisfied.

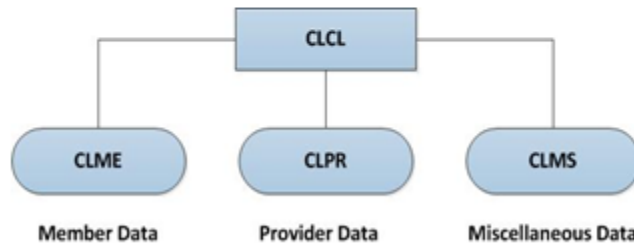


## XC Electronic Adjudication Tables

### XC Electronic Adjudication Tables



- ▶ **CMC\_CLME\_MEMBER**
- ▶ **CMC\_CLPR\_PROVIDER**
- ▶ **CMC\_CLMS\_EXT\_MISC**
- ▶ **After adjudication of claim in Facets, all claim-related information is no longer available in tables**



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

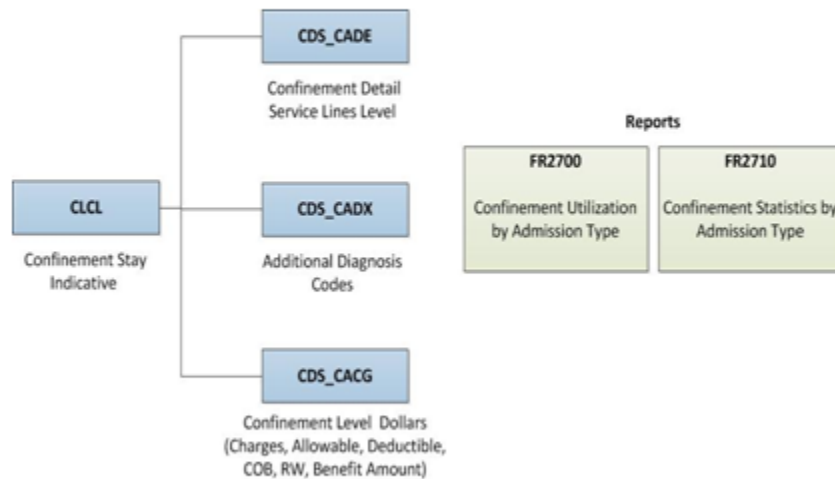
After Facets adjudicates a claim, all claim-related information no longer displays in these tables.

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



## Inpatient Confinement Reporting

### *Inpatient Confinement Reporting / ERCDSRUNCONF.XML Batch*



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

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

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





## Objective Summary

You are now able to:

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



## Coming Up

### *Coming Up*



**Next we will discuss:**

► **Accounting Data Model**