Claims Processing

Facets 5.0
Participant Guide

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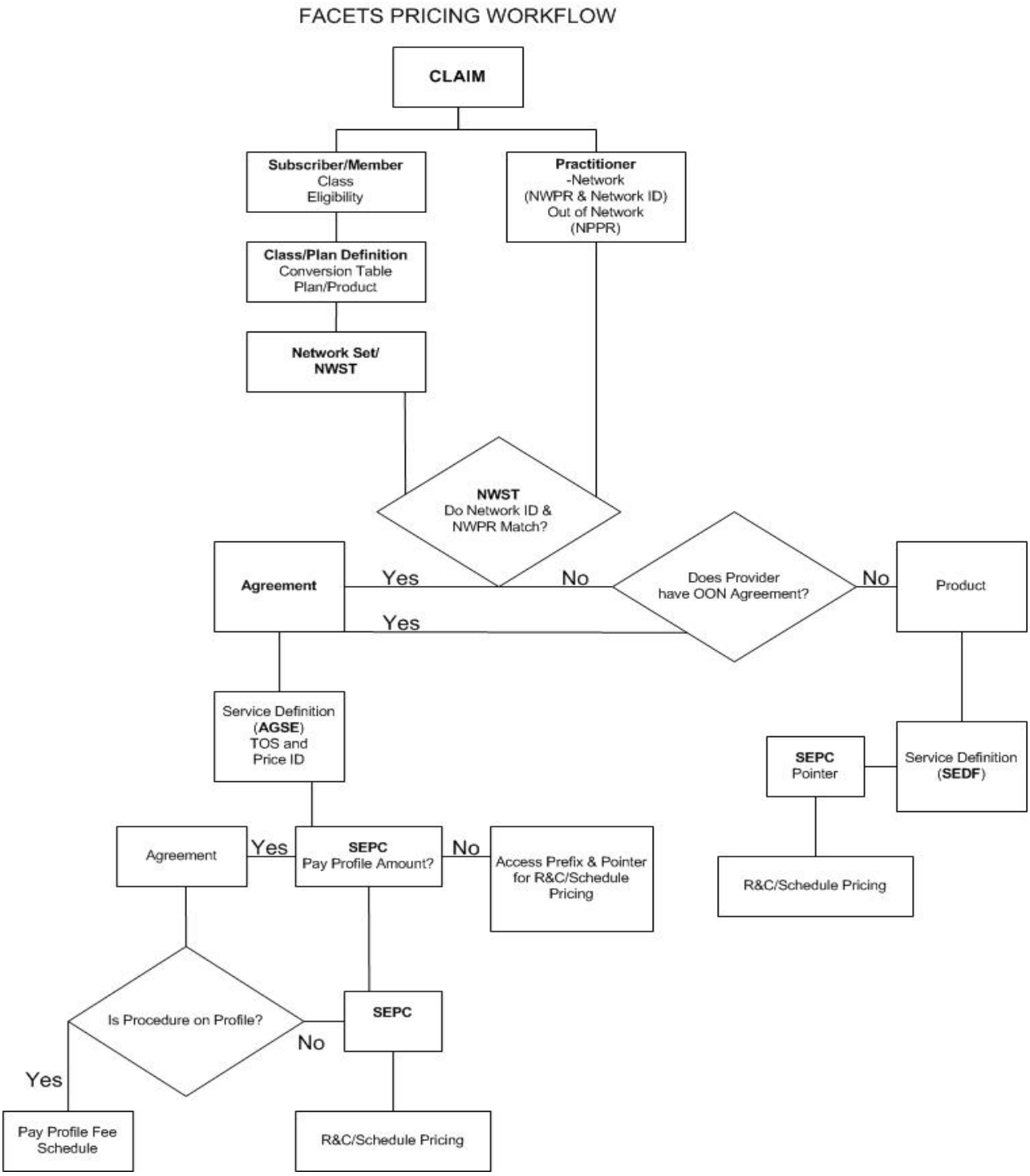
Facets Pricing Workflow



Facets Claim Flow

1. Facets performs some basic input editing on the claim as it's being entered (e.g. is the Subscriber ID valid, is the provider ID valid, etc.). If errors are found, they must be resolved before the claim can continue to process.
2. After a claim has been completely entered in Facets, select **F3** to process.
3. After Facets finishes the basic input editing, eligibility is checked. The group must have a valid class/plan record and the member must have an eligibility row:

   - If the member is found to be ineligible, Facets will deny the claim and will not go through any additional processing unless eligibility is overridden.
   - If a claim is submitted for a Product Category and the member does not have eligibility established for that category, Facets automatically disallows the claim and keeps the denied claim on file.

Note: This process does not eliminate the requirement to split claims that cross product categories.

- Facets reads the Plan Descriptions application, as well as the member's product, for error plan and product codes. The error plans/products are used system wide in Facets for Product Categories M (Medical) and D (Dental). Therefore, Facets reads the Plan Descriptions application to see if it contains the pre-defined value of ERRPLANM (Medical Error Plan) and ERRPLAND (Dental Error Plan), as well as the Product table for pre-defined values of ERRPRODM (Medical Error Product) and ERRPRODD (Dental Error Product). When Facets encounters a claim for a Product Category the member does not have eligibility for, it reads the Plan Descriptions and Product records to determine if an error plan and product are established for that Product Category. If established, Facets automatically disallows the claim with the explanation code S5 (Member not Eligible for Product Category). If Facets does not find an error plan and product for the Product Category, existing functionality applies and the claim errors.

Note: The user may deactivate this disallow functionality by deleting the supplied error plans.

- **FYI…**An element to the data returned during the eligibility check logic indicates whether or not an additional family member also has eligibility in the same plan for the line being processed. The eligibility process will interrogate the member's eligibility, and determine if there are any other family members with eligibility for the same **Plan ID** and date. If this logic determines that a family size of one applies, the deductible and stoploss amounts will be determined based on individual eligibility. If this data element determines that a family size of greater than one applies, the deductible and stoploss amounts will be based on family eligibility. Claims processing does not read the **MEPE Family Indicator** to determine family size when a tiered deductible and/or tiered stoploss is indicated. Instead, the logic in the claim adjudication eligibility check process makes the family size determination. **Family Indicator** is informational only regarding tiered stoploss.

- If the eligibility check results in a warning message, the claim will continue through the flow. However, the warning message will appear on the claim.

4. By determining if the member is eligible or ineligible, Facets will also recognize the class that is assigned to the subscriber. If a class was not assigned to the subscriber, an error would have occurred in step #3. With knowledge of the class, Facets also knows the Service Conversion prefix that is used to open one of the following three applications: Service/Procedure Conversion, Service/Revenue Code Conversion, or Service Code Conversion. The determination of which application is opened is made by the type of claim (medical vs. hospital) being processed, as well as how a service was identified on each line item. This conversion process will result in Facets determining a TOS / Service Code (ID) for each service entered on each line item of the claim.

   - If the service conversion process cannot be completed, Facets will produce an error.
   - Depending on the type of claim being processed, and if the valid components are active on the product, Facets may access either the Supplemental/Procedure Conversion or Supplemental/Revenue Code Conversion tables to change the initial TOS (type of service) code found, to a different TOS code.

Note: If a TOS code has not been defined on the Service ID Description application, this entire process will result in an error.

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5. After Facets completes the eligibility check and finds the appropriate plan/product for the member, Facets performs provider/network edits.

   - If an error message occurs, the provider set-up is incorrect and Facets will discontinue processing.
   - Any warning messages discovered at this level (e.g. provider is out-of-network) will appear on the claim, but the process will continue.

6. If a provider agreement is found, Facets will obtain the Service Definition (AGSE) prefix from the agreement. If a provider does not have an agreement, the Service Definition prefix will be obtained from the product's SEDF component. The Service Definition will state which services have referral and/or pre-authorization requirements, which services are capitated, if a risk-withhold will be taken, and it will also identify the Service Pricing ID that Facets accesses to determine the pricing method used to price a service.
7. Facets then performs a duplicate check for each claim line. If an exact duplicate is discovered, Facets will follow the process outlined in the Duplicate Claim Rules (DUMD) component on the Product, and if disallowed, further processing will not be checked. If the claim is not an exact duplicate, Facets will continue the claim flow process.
8. Facets will then perform the managed care edits, checking for referrals and authorizations based on the AGSE/SEDF found in Step 6 above.

Note: There are other applications in Facets besides the Service Definition application that can identify if a service requires a referral or authorization.

9. Facets performs clinical editing, disallowing, and warning where appropriate. If a line is disallowed due to a clinical edit, it will not continue through the process.
10. Facets determines additional product prefixes and obtains the allowable price for each service on a claim line.

Note: In determining the allowable price, Facets must also determine if the allowable price is defined with a counter or an amount service rule. This is determined by the service rule linked to the TOS code in the Service Payment (SEPY) application. If the rule indicates counter, Facets multiplies the number of units on the line by the allowable price. If the rule indicates amount, regardless of the number of units on the line, the allowable amount is a flat rate. This functionality is subject to the type of pricing method indicated on the Service Pricing application (e.g. DRG pricing.)

11. After determining the price, Facets applies benefits to the line based on the SEPY (Service Payment), DEDE (Deductible), and LTLT (Limit) rules tied to the product. To determine if deductible and/or limit accumulators have been met, Facets will verify the Member and Family Accumulator applications.
12. Finally, Facets checks the Coordination of Benefit Rules (CBCB) and edits the claim accordingly.

Note: If Facets hits an error message in any of the above steps, processing will discontinue. Error messages may be received due to various conditions. If the line is disallowed based on a processing action, Facets discontinues processing at the point of disallow. If the claim hits a warning message during any of the above steps, processing continues and the claim suspends only based on security level.

13. After the claim has gone through the entire flow, a payment amount will be determined and drag provisions applied. When the claim is accepted as complete through **Save…Accept** from the **File** menu/**Ctrl+S** (status = 01), accumulators are updated and the claim is tagged with a system action row to show it is awaiting batch status

Facets/NetworX*Pricer* Claim Flow

1. Facets performs some basic input editing on the claim as it is being entered (e.g. is the **Subscriber ID** valid, is the provider ID valid, etc.). If errors are found, they must be resolved before the claim can continue to process.
2. After a claim has been completely entered in Facets, select **F3** to process.
3. After Facets finishes the basic input editing, eligibility is checked. The group must have a valid class/plan record and the member must have an eligibility row:

   - If the member is found to be ineligible, Facets denies the claim and will not go through any additional processing unless eligibility is overridden.
   - If a claim is submitted for a Product Category and the member does not have eligibility established for that category, Facets automatically disallows the claim and keeps the denied claim on file.

Note: This process does not eliminate the requirement to split claims that cross product categories.

- Facets reads the Plan Descriptions application, as well as the member's product, for error plan and product codes. The error plans/products are used system wide in Facets for Product Categories M (Medical) and D (Dental). Therefore, Facets reads the Plan Descriptions application to see if it contains the pre-defined value of ERRPLANM (Medical Error Plan) and ERRPLAND (Dental Error Plan), as well as the Product table for pre-defined values of ERRPRODM (Medical Error Product) and ERRPRODD (Dental Error Product). When Facets encounters a claim for a Product Category for which the member does not have eligibility, it reads the Plan Descriptions and Product records to determine if an error plan and product were established for that Product Category. If established, Facets automatically disallows the claim with the explanation code S5 (Member not Eligible for Product Category). If Facets does not find an error plan and product for the Product Category, existing functionality applies and the claim will error.

Note: The user may deactivate this disallow functionality by deleting the supplied error plans.

- **FYI…**An element to the data returned during the eligibility check logic indicates whether an additional family member also has eligibility in the same plan for the line being processed. The eligibility process will interrogate the member's eligibility, and determine if there are any other family members with eligibility for the same **Plan ID** and date. If this logic determines that a family size of one applies, the deductible and stoploss amounts will be determined based on individual eligibility. If this data element determines that a family size of greater than one applies, the deductible and stoploss amounts will be based on family eligibility. Claims processing does not read the **MEPE Family Indicator** to determine family size when a tiered deductible and/or tiered stoploss is indicated. Instead, the logic in the claim adjudication eligibility check process makes the family size determination. **Family Indicator** is informational only regarding tiered stoploss.

- If the eligibility check results in a warning message, the claim will continue through the flow. However, the warning message will appear on the claim.

4. By determining if the member is eligible or ineligible, Facets will also recognize the class that is assigned to the subscriber. If a class was not assigned to the subscriber, an error would have occurred in step #3. With knowledge of the class, Facets also knows the Service Conversion Prefix used to open one of the following three applications: Service/Procedure Conversion, Service/Revenue Code Conversion, or Service Code Conversion. The determination of which application is opened is made by the type of claim (medical vs. hospital) being processed, as well as how a service was identified on each line item. This conversion process will result in Facets determining a TOS / Service Code (ID) for each service entered on each line item of the claim.

   - If the service conversion process cannot be completed, an error displays.
   - Depending on the type of claim being processed, and if the valid components are active on the product, Facets may access either the Supplemental/Procedure Conversion or Supplemental/Revenue Code Conversion tables to change the initial TOS (type of service) code found, to a different TOS code.

Note: If a TOS code has not been defined on the Service ID Description application, this entire process will result in an error.

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5. Once Facets has completed the eligibility check and found the appropriate plan/product for the member, Facets performs provider/network edits.

   - If an error message occurs, the provider set-up is incorrect and Facets will discontinue processing.
   - Any warning messages discovered at this level (e.g. provider is out-of-network) will appear on the claim, but the process will continue.

6. If a provider agreement is found, Facets obtains the Service Definition (AGSE) prefix from the agreement. If a provider does not have an agreement, the Service Definition prefix is obtained from the product's SEDF component. The Service Definition will state which services have referral and/or pre-authorization requirements, which services are capitated, if a risk-withhold will be taken, and it will also identify the Service Pricing ID Facets accesses to determine the pricing method used to price a service.
7. Facets then performs a duplicate check for each claim line. If an exact duplicate is discovered, Facets will follow the process outlined in the Duplicate Claim Rules (DUMD) component on the product, and if disallowed, further processing will not be checked. If the claim is not an exact duplicate, Facets will continue the claim flow process.
8. Facets will then perform the managed care edits, checking for referrals and authorizations based on the AGSE/SEDF found in Step 6 above.

Note: There are other applications in Facets besides the Service Definition application that can identify if a service requires a referral or authorization.

9. Facets performs clinical editing, disallowing, and warning where appropriate. If a line is disallowed due to a clinical edit, it will not continue through the process.
10. An allowable price is found for the service on each line item of the claim using NetworX applications that are integrated in Facets.
11. After determining the allowable price for a line item, Facets must determine the actual payment or benefit related to the service, by subtracting out of pocket expenses from the allowable price. This step requires that Facets first determine if the allowable price will be subject to a counter or an amount service rule. This is determined by the service rule linked to the TOS code in the Service Payment (SEPY) application. If the rule indicates Counter as the **Type**, the line item units could be subject to an allowable counter limit. If the rule indicates Amount as the **Type**, the line item allowable price could be subject to an allowable amount limit. If the rule type indicates Disallowed, the allowable units and the allowable price will be set to 0 units allowable and $0.00 allowable, respectively.
12. After determining the **Service Rule Type**, Facets applies benefits to each line item based on the SEPY (Service Payment), DEDE (Deductible), and LTLT (Limit) rules tied to the product. To determine if deductible and/or limit accumulators have been met, Facets will verify the Member and Family Accumulator applications.
13. Finally, Facets checks the Coordination of Benefit Rules and edits the claim accordingly.

Note: If Facets hits an error message in any of the above steps, processing will discontinue. Error messages may be received due to various conditions. If the line item is disallowed based on a processing action, Facets discontinues processing at the point of disallow. If the claim hits a warning message during any of the above steps, processing continues and the claim suspends only based on security level.

14. Once the claim has gone through the entire flow, a payment amount (benefit) will be determined and drag provisions applied. As the claim is accepted as complete through **Save…Accept** (**F4**) from the **File** menu/**Ctrl+S** (status = 01), accumulators are updated and the claim is tagged with a system action row to show it is awaiting batch status.

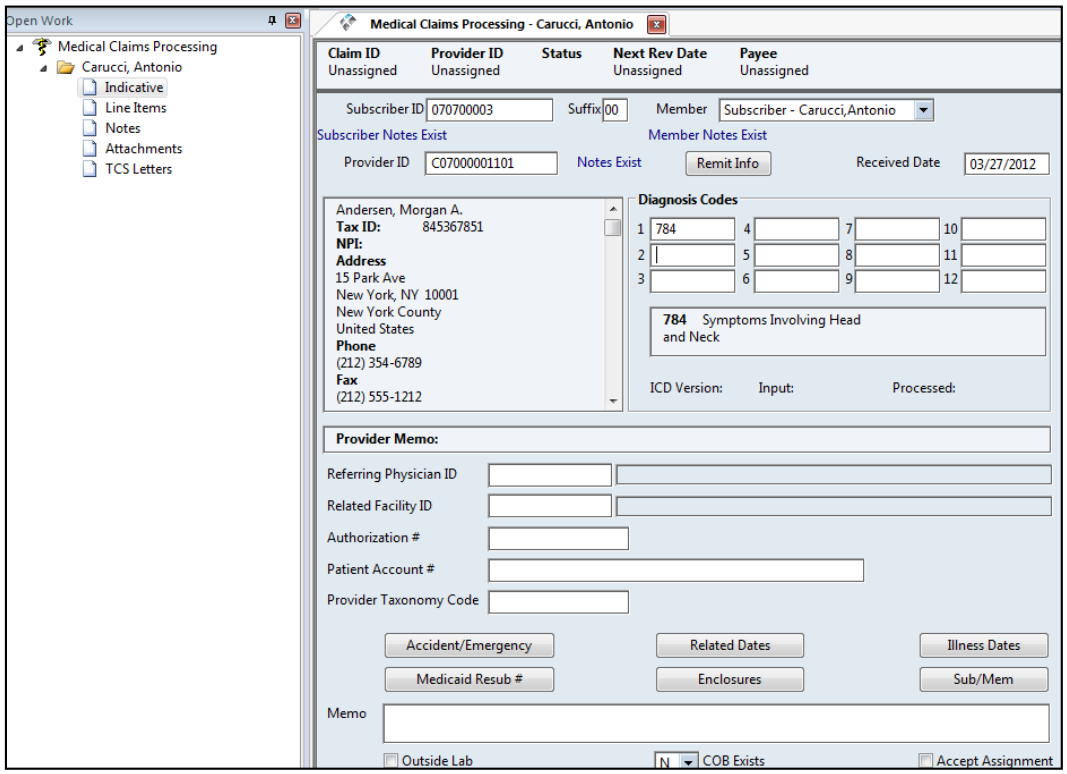
Medical Claims Processing Application

Entering a Medical Claim

Step		Entering a Medical Claim Procedure
Steps denoted with an * are required.		
1	*	Tab into the **Indicative** section and enter the subscriber Id, suffix, member name, provider Id, and Diagnosis. Facets checks for eligibility based on the information entered in the **Indicative** section.

Indicative Section

Use this section to identify the subscriber, provider, and referring physician associated with a claim, and enter corresponding diagnosis and patient account information. Users are also notified that notes or memos exist for the provider, subscriber, and/or member in informational blue text. Control buttons and menu commands allow users to view and enter additional claim-related information. Users also may copy information from an existing claim to create a new one.



Field/Button		Description
Fields denoted with an * are required.		
Subscriber ID	*	Enter the **Subscriber ID** for this claim.
Suffix	*	Enter the member suffix (00, 01, etc.) to identify the patient. This field will automatically populate if a selection in the **Member** field is completed first.
Member	*	Select the correct relationship and name of patient.
Provider ID	*	Enter the ID of the servicing provider.
Remit Info button		Allows users to view the payee name, provider entity and remittance addresses.
Received Date	*	Will auto-populate with today's date; may be changed.
Diagnosis Codes	*	Enter the diagnosis codes for this claim (up to 10 characters). At least one entry (a primary diagnosis) is required and should be entered in field **1**, however Facets accepts up to 12 codes. Select **Search** from the **Edit** menu (**Alt+E+S**) or the **F7** key to find a diagnosis code.
ICD Version: Input:		System generated. Facets displays the input ICD-9 or ICD-10 code based on the entries on the claim. If there is a mixture of ICD-9 and ICD-10 codes, an error message displays.
ICD Version: Processed:		System generated. Facets derives the value in this field, ICD-9 or ICD-10, based on the ICD version used to process the claim. This is based on the date of service for medical claims. If the dates of service are greater than or equal to the ICD-10 processing effective date, this field will display ICD-10; otherwise ICD-9 displays.
Provider Memo		Display only; this field is populated from the **Memo** field of the provider's application.
Referring Physician ID		Enter the ID of the referring physician.

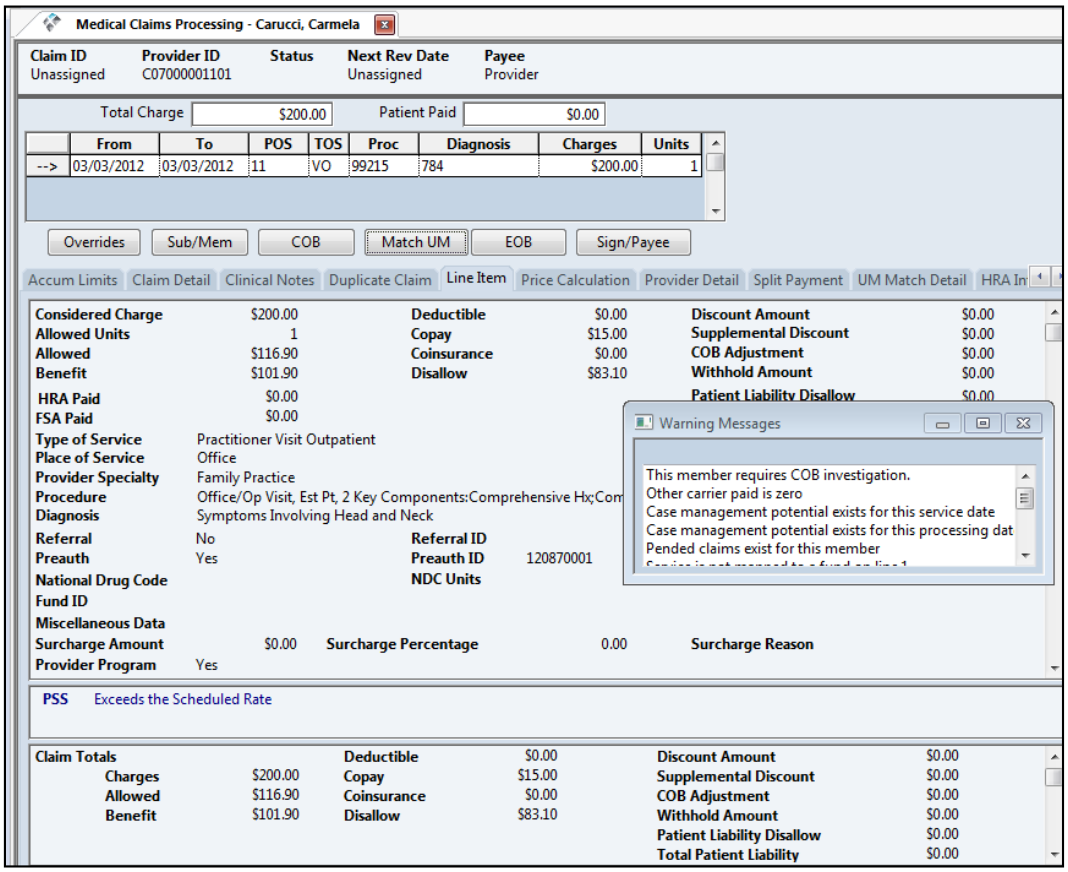
Field/Button		Description
Related Facility ID		Enter the **Related Facility ID** for this claim. Select **F7** to conduct a search.
Authorization #		Enter any authorization number the user wants to store.
Patient Account#		Enter the patient's account number. This allows for compliance with HIPAA requirements and also allows Facets to process incoming compliant EDI 837 claims. In addition, it affects all applications that display or allow the user to enter the **Patient Account Number**.
Provider Taxonomy Code		CMS (Centers for Medicare and Medicaid Services) requires the **Provider NPI** and **Taxonomy Code** to identify organizational subparts requiring alternate reimbursement. Enter the taxonomy code for this provider that is specific to his/her specialty. This code is used for data capture and reporting only. **Note:** Facets does not edit this entry.
Accident/Emergency button		Use this dialog box to specify the details of an accident or emergency relating to this claim.
Related Dates button		Enter the dates the member was hospitalized or unable to work under the current services.
Illness Dates button		Enter the date the illness began.
Medicaid Resub # button		This option allows users to access the dialog box to enter the **Medicaid Resubmission Number** for this claim (information only).
Enclosures button		Select this button to indicate whether external referrals, medical records, EOBs for COB calculations and/or X-rays have been obtained and attached to this claim.
Sub/Mem button		A user may access subscriber/member information related to a claim from either the **Indicative** or **Line Items** section, the **Actions** menu (**Alt+A+B**) or by using the hot key combination of **Ctrl+B**. This button allows the user to open the **Subscriber/Member Information** dialog box and view subscriber/member information entered for a claim, such as address(es), birth date, Social

Field/Button		Description
		Security Number, group, plan, and PCPs. This window is informational only.
Memo		Enter a free-form memo pertinent to the claim.
Outside Lab		Indicate whether any services on the claim relate to an outside laboratory (informational only).
COB Exists		Select whether or not coordination of benefits (COB) exists for this claim (informational); this option accommodates ITS claim processing functions. **Note:** If an ITS claim is being processed, additional values will display for this field. Refer to the ITS Processing Guide for a description of these values.
Accept Assignment		Check this box if the servicing provider accepts Medicare.

Step		Entering a Medical Claim Procedure (continued)
Steps denoted with an * are required.		
2	*	After entering information in the **Indicative** section, go to the **Line Items** section and enter line item information.
3		Select **Enter** after entering the number of units to add an additional line if the claim has multiple line items.

Line Items Section

This section contains an enterable grid in which claim line item information is entered and viewed for the member's claim. Also included are control buttons, menu commands, and section tabs that allow the user to enter and/or view additional claim-related details for a selected line item.



Field		Description
Fields denoted with an * are required.		
Total Charge	*	Enter total charges for the claim.
Patient Paid		Enter any amount already paid to the provider. Facets splits payment between the subscriber and provider if the **Split Payment Method** is selected in the AIAI.
From/To	*	Enter the **From** and **To** dates relative to this line item.
POS	*	Enter the **Place of Service** code for this line item.
TOS		The **TOS** for this line item. If the Service/Procedure code Conversion table is accessed, a **TOS** entry displays here based on the entry in the **Proc** field.

Field		Description
Proc	*	Enter the CPT code for this line item.
Diagnosis	*	Enter the **Diagnosis** code that pertains to this line item (must have been entered in the **Indicative** section).
Charges	*	Enter the charges for this line item.
Units	*	Enter the number of units/counters for this line (up to 9,999).

Step		Entering a Medical Claim Procedures (continued)
Steps denoted with an * are required.		
4	*	After line items have been entered, process the claim by selecting **F3** or **Process** from the **File** menu. Once the adjudication is complete, Facets displays any error and/or warning messages pertaining to the claim (see screen print above).

Note: A warning message will not prevent the user from accepting the claim. However, if an error message displays, the error must be resolved before a claim may be fully processed and accepted.

Step		Entering a Medical Claim Procedures (continued)
Steps denoted with an * are required.		
5		View adjudication information in the section tabs and menu options (shown on the following pages).
6		Enter additional information through the button and menu options (shown on the following pages).

Step		Entering a Medical Claim Procedures (continued)
Steps denoted with an * are required.		
7	*	Select **Save** from the **File** menu and select from the following menu options to save the claim: • **Accept** (**F4**) • **Accept/Continue** (**Shift+F4**) • **Pend** (**F5**) • **Pend/Continue** (**Shift+F5**) • **Route** (**Shift+F8**) • **Closed**

Note: Facets does not restrict users from manually entering any amount of line items in any claims application. For electronic submissions, institutional (hospital), 837 logic will error if more than 999 line items are submitted. For dental and professional (non-hospital), 837 logic will error if more than 50 line items are submitted.

Medical Claims Processing Section Tabs

Section tabs in the **Line Items** section provide additional information about the claim being processed, such as duplicate information, line item details, price calculation information, clinical notes, and details about UM reviews that match the claim. After a claim is adjudicated, the **Line Item** section tab displays first.

Line Items Section

This section contains an enterable grid in which the user may enter and view line item information for this member's claim.

Line Item Section Tab

This section tab displays adjudication information for the line selected. Specific data such as allowable amount, deductible, co-pay, coinsurance, disallow, COB, and benefit amounts display for each line. To view additional line item information for this claim, select a line in the grid at the top of the section and select the appropriate section tabs to view information in the text-out area below the section tab options.

Price Calculation Section Tab

This section tab shows pricing details, such as the service rule, service pricing, and any type of agreement or other pricing arrangements. It also displays NetworX pricing details, as well as the source of the price used in calculation for the selected line item. This section tab includes a grid to accommodate multiple NetworX pricing tables. Select a row from the section grid to review the price calculation and NetworX pricing details associated with that claim line.

Note: Claims priced using NetworX are bypassed instead of pended in scenarios where the NetworX module is either unavailable or it fails. This allows these claims to be picked up by subsequent batch job runs once the NetworX issue is resolved.

Accum Limits Section Tab

Select the **Accumulator Number** in the grid to view limit and deductible accumulator information in the text-out area below the grid.

Claim Detail Section Tab

This section tab displays details relating to this member's claim including accident or emergency details, dates the member was not able to work in his/her current position, hospital stay dates, as well as dates of illness. To view additional details for this claim, select a line item in the grid at the top of this section and view the text-out area below the section tabs.

Clinical Notes Section Tab

This section tab holds any clinical editing data relevant to the line item(s) selected. If any clinical edits occur during processing, they display here.

Duplicate Claim Section Tab

This section tab lists all claims in history that may be duplicates of the current claim. Refer to the *Product Components* chapter for more information on the Duplicate Claim Rules application.

Provider Detail Section Tab

This section tab provides details on the servicing provider, referring provider, related facility, and the member's PCP.

Split Payment Section Tab

This section tab provides information on subscriber and provider payment amounts for each selected line item.

UM Match Detail Section Tab

This section tab holds claim/UM match details. If the current claim matches a pre-authorization or referral in history, those reviews display here. Also displayed is "Unlim" (unlimited) in the **Units** field when a claim matches to a UM episode with unlimited authorized units. When the matching UM episode contains Unlimited Requested Units, the **Overrides-Units** label displays Unlimited Units. When both Unlimited Requested Units and Unlimited Authorized Units exists, the **Overrides Units** label will display both.

Medical Claims Processing Menu Options

The dropdown menus from the menu bar will also allow the user to enter additional information necessary to processing a claim.

The following options may be selected from dropdown menus:

File Menu Option	Description
Inquiry (Alt+F+I)	Select this option to find a claim.
Process (F3)	Select this option to process the claim.
Save	Select this option to save the claim. Options include: • **Accept (F4)** • **Accept/Continue (Shift+F4)** • **Pend (F5)** • **Pend/Continue (Shift+F5)** • **History Update (Shift+F6)** • **Route (Shift+F8)** • **Closed**
Auto Numbering	This option indicates if auto-numbering is turned-on.
Void (Ctrl+D)	This option allows claims with a status of 02 (Accepted, Batch Complete) to be voided. The original claim is assigned a status of 91 (Adjusted Claim) and cannot be re-opened; the new segment is 01. **Note:** Security is linked to this functionality.
Void/Reissue (Ctrl+E)	This allows claims with a status of 02 (Accepted, Batch Complete) to be voided and reissued. **Note:** Security is linked to this
Search (Alt+S or F7)	Select this option to search for information pertaining to the claim.
Address Selection / Alt+E+A (from the **Indicative** section)	This allows the user to select a service location for the servicing provider and direct correspondence to that location's mailing address. **Note:** If the provider only has one service location, this dialog box will not display. **Note:** Selecting a different service location will not affect pricing; pricing is still based on the servicing provider's primary address/zip code. To vary pricing by service location, establish multiple provider IDs.

File Menu Option	Description
Delete (Alt+E+D)	Select this option to delete the selected claim line.
External Price (Atl+E+L)	Select this option to enter a price obtained outside of Facets on a line item. Enter information in the **Line Item External Price** dialog box.
Duplicate Claim / F8 (Alt+E+I)	Facets provides functionality that allows the user to recall an existing claim on-line, make a copy of that record, enter or modify information to reflect key elements of the new claim record and then save that new record with a new claim ID. **Note:** Facets does not copy the current claim ID, overrides, user-defined EOB codes at the claim and line item level, letter attachments or alternate payee information to the new claim record.
Select to Move (Ctrl+M)	Select this option to transfer line items from an existing claim segment to a new claim segment.
Select to Move by Date (Alt+E+O)	Select this option to transfer line items from an existing claim segment to a new claim segment by date. Enter the date in the dialog box.
Duplicate Line (Alt+E+U)	Select the line item and select this option from the menu to add a duplicate of an existing line to the grid.
View Selected Lines (Alt+E+V)	When this option is selected, the **Selected Lines to Move** dialog box displays each of the lines selected to be moved.

Actions Menu Option	Description
Accident or Emergency (Alt+A+I)	Use the **Accident Or Emergency** dialog box to specify the details of an accident or emergency for the current claim. Entering information in this dialog box will require Accident/Emergency Types of **Variable Component** rows on the member's product.
Add Disallow to COB Calc (Alt+A+T)	Select this option to access the **Add Disallow to COB Calc** dialog box used to credit claim level or line item level disallow amounts to the member's COB calculation balance. This gives the user the choice of including all or a portion of any disallowed amount generated from the adjudication routine

Actions Menu Option	Description
	towards the amount of disallow to be reimbursed.
Condition Codes (Alt+A+N)	Select this option to enter condition codes in the **Condition Codes** dialog box.
Coordination Of Benefit (Alt+A+C)	See information under Claims Processing Buttons and Action Menu options.
EOB Explanations (Alt+A+E)	Select this option to select a pre-defined message to appear on the EOB.
External Preauthorization/ Referral	Up to 18 alphanumeric characters for each number. This option distinguishes between the referral and preauthorization number coming from an external system via the EDI 5010 process. In the **External Preauthorization/Referral** dialog box, enter the **Preauthorization** and/or **Referral** number related to this claim.
ITS Data (Ctrl+I)	Select this option to enter Interplan Teleprocessing System (ITS) claim level and line item level data for the current claim. Purchased separately.
Match UM Reviews (Alt+A+U)	See information under Claims Processing Buttons and Action Menu options.
Override / (Alt+A+O+C/L)	See information under Claims Processing Buttons and Action Menu options.
Signature/Payee Information (Alt+A+S)	Indicate authorizations made by the member regarding claims payments and the release of pertinent medical information. When a provider has not collected a patient signature for release of treatment information and state or federal laws do not require it, the option of **Informed Consent** may be selected as the method of treatment information release. **Note:** Select the **Assignment of Benefits Exist** checkbox if the subscriber has signed an agreement authorizing a third party payer to pay the provider (informational only).
Replace Deleted Codes (Alt+A+R)	If a procedure code used on the claim is outdated, Facets automatically replaces it. However, if there are multiple replacement codes, the user must select this option and pick the appropriate code.
Related Dates	Select this option to view or update the dates the

Actions Menu Option	Description
(Alt+A+D)	member was unable to work or was hospitalized under the current services.
Illness Dates (Alt+A+N)	Select this option to view or update illness dates for this member.
Micro/Image ID	Enter a corresponding Microfilm ID or imaging address for the claim.
Outside Lab Amount	Select this option to enter an outside lab amount for the claim. (This selection is available if the **Outside Lab** checkbox is selected in the **Indicative** section of the Medical Claims Processing application).
Additional Modifiers (Ctrl+T)	This allows users to enter three additional (one or two character) modifiers to describe a claim line. The order these modifiers are applied in the final price calculation is based on modifier information found in the Modifier Hierarchy record (Application Support application group) and the Modifier Pricing Rules record (Medical Plan application group).
Additional Diagnosis Codes (Ctrl+U)	This dialog box allows the user to enter seven additional line item diagnoses for a selected claim line (line item level). These additional diagnoses are used for reporting purposes only. **Note:** Only the primary diagnosis entered for a line will be respected by the adjudication routine.
Claim Adjustment Reason	This option allows users to identify why a previously paid claim has been adjusted.
Provider Payment Adjustment	An extension must be added in order to access this option; informational only. Used to apply out-of-pocket to member-accumulators and not reduce the provider's payment amount.
Medicare Supplement (Ctrl+L)	This dialog box allows the user to enter claim level and line item amounts from the Medicare carrier for a member's claim. When claim level amounts are entered, Facets prorates the amounts across the line items using the standard proration routine based on the claim charges. The claim level **Reason Code** is applied to each line item. During the proration routine, Facets ignores any excluded line items. When the user enters amounts by line item, Facets ensures the line total equals the claim

Actions Menu Option	Description
	total.
Miscellaneous Data	Select this option for the appropriate line that miscellaneous data applies. If the user enters a **Miscellaneous** data value for the selected line along with the **Explanation Code**; the value of XR – Miscellaneous Value is the explanation code that identifies a miscellaneous data line-level override. **Ambulance** mileage to the 10th of a mile can also be entered in this dialog box. These options are informational only.
National Drug Code	See information under Claims Processing Buttons and Action Menu options.
Provider Surcharge	Use this option to add a surcharge amount to the considered charges of a provider's claim. This option is used in addition to an extension in order to pull-in the provider's surcharge.
Subscriber/Member (Alt+A+B or Ctrl+B)	Select this option to view subscriber and member details for the claim.
Alternate Funding Overrides	Select this option to select the Alternate Funding (AF) contract period for a line item that will be applied during the AF billing process.
Original Submission Data / Claim or Line Item	This option is part of Encounter and Redirect Processing in the Facets Assigned Risk Module that supports the redirection of submitted claims to the proper entity for processing.
Ambulance Pickup Zip	Enter the zip code for the pickup location used in determining service area for ambulance medical claims. **Note:** This pertains to DOFR/Assigned Risk and Service Area processing.
Rendering Provider	Enter the ID of the provider who treated the member. The rendering provider may be different from the billing provider. **Note:** This pertains to DOFR/Service Area processing.
Service Location Zip Code	Enter the zip code for the service location on which professional services pricing is based. If entered at the claim level, all lines on the claim will be priced based on the zip code entered. If entered at the line

Actions Menu Option	Description
	level, only the selected lines on the claim will be priced based on the zip code entered. The service location zip code entered on the claim is passed to Networ*XPricer*.
Manual ICD Translation	See information under Claims Processing Buttons and Action Menu options.
Gateway Ref ID	Use this option to attach a **Reference ID (GWID)** for HIPAA Gateway.
Change Member Information (Alt+A+M+P/A/S/C)	Select this option to change member PCP, Address, Student Status, and COB information.

Supplemental Menu Option	Description
Claim	This option is part of the Facets Assigned Risk Module that allows users to enter and view DOFR-related data (Division of Financial Responsibility), as well as Encounter and POS processing.
Overrides	These overrides support FARM, POS processing requirements, and Workflow Prudent Layperson. For more information classes are available for FARM and Workflow.

View Menu Option	Description
Accumulators (Alt+V+A+C/D/L)	Select this option to view the member and family accumulator. **Note:** A transfer to the Member and Family Accumulator applications is available.
Adjustment Details	View underpayments or overpayments in claims processing when recalling and adjusting a previously paid claim. These amounts are approximations based on the total of the subscriber and provider paid amount fields, and may not always accurately reflect totals, since additional payments or discounts (i.e. interest or prompt payment discounts) could be applied during the payment batch. The **Adjustment Details** dialog box includes a disclaimer to alert users. **Note:** This feature is enabled only for claims having a status

View Menu Option	Description
	of 02 – Accepted, Batch Complete. Amounts appearing in this dialog box are informational only and cannot be edited.
Benefit Summary / Alt+V+B (F6)	View the benefit summary information for the product.
Claim View	This dialog box allows the user to quickly view adjudication details of a selected line. It can assist Customer Service representatives in answering inquiries, as it presents adjudicated information in full sentences and easy-to-read format. The data is limited to existing data saved with the claim and lines, and is presented in the order of the adjudication flow. The text at the top includes the dates of service, provider, charges, and status of the claim. If applicable, CDH data is available.
Debit Card History	The **Debit Card History** dialog box allows users to select parameters and view swipe history stored in the Facets database. **Note:** This option pertains to CDH.
HRA Balances	This dialog box assists users in accounting for both future and current year accumulator balances when carryover dollars are being used to pay an HRA claim; it helps to determine the true available balance and allows users to consider HRA dollars spent in other years.
Product and Prefixes (Alt+V+P)	Select this option to view product and plan component prefixes used to adjudicate the claim.
Related Notes (Alt+V+R)	Select this option to view Subscriber, Member, Provider, and Service Provider Agreement notes, if they exist, as they relate to this claim.
Remittance Info (Alt+V+M)	Select this option to view payee name, provider entity and remittance address associated with this claim.
Status (Alt+V+S)	Select this to view the status of the currently opened claim (already saved).
Utilization Notes (Alt+V+U)	View notes for referrals and pre-authorizations associated with this claim.

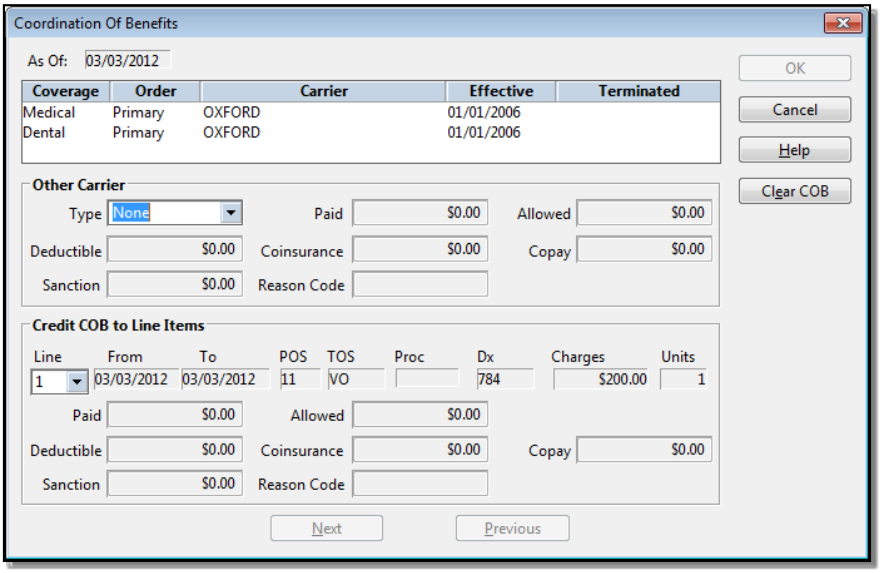
Medical Claims Processing Buttons and Actions Menu Options

Actions Menu

Coordination Of Benefits Dialog Box (COB Button)

Enter COB information in the **Line Items** section (lower part of the dialog box). Facets will prorate COB amounts on a line-by-line item basis. To view other line items for this claim, select the **Previous** or **Next** buttons. Select **OK** when done making the selections (see next page for field descriptions).

Facets allows the user to process coordination of benefits (COB) for claims in which COB rules apply, but other carrier' information has not been entered on the member record. The **Other Carrier** fields in this dialog box include fields that are used to store other carrier amounts. With the exception of the **Other Carrier Sanction** amount, these fields are used for reporting purposes only.



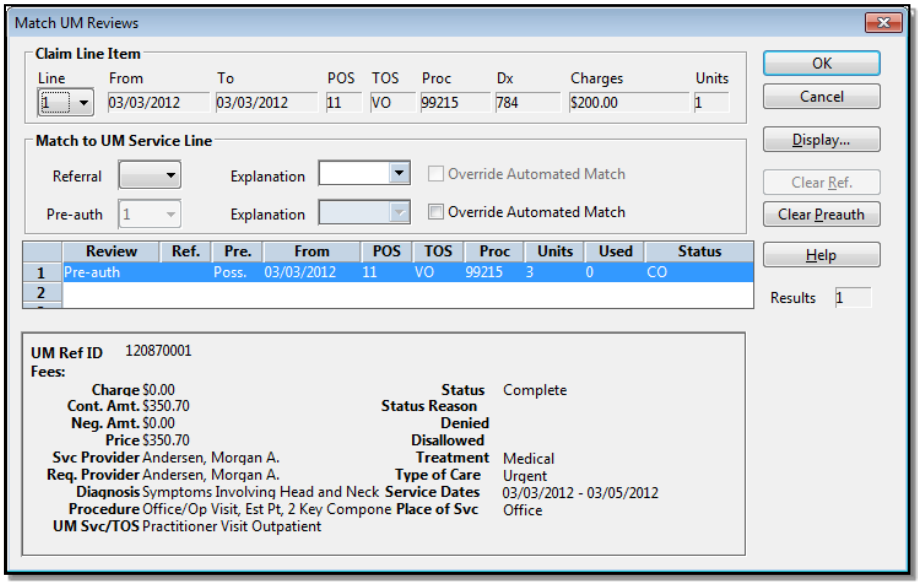
Field		Description
Fields denoted with an * are required.		
Other Carrier: Type		Select the appropriate option to define the type of other coverage.
Other Carrier: Paid		Enter the primary carrier's paid amount to be applied towards the claim in the COB processing routine.
Other Carrier: Allowed		This field is only used when the **COB Calculation Method** selected in the COB Rules record found on the member's product is the higher of the two carriers' allowable amounts (H – Coordinate to the

Field		Description
		higher allowable). When used, this value identifies the primary carrier's allowable amount for the claim. Facets uses the higher of this value, or the allowable from the secondary carrier (i.e., Facets allowable in the absence of COB with primary carrier).
Other Carrier: Deductible		Enter the deductible amount applied by the other carrier.
Other Carrier: Coinsurance		Enter the coinsurance amount applied by the other carrier.
Other Carrier: Copay		Enter the copay amount applied by the other carrier.
Other Carrier: Sanction		Enter the sanction amount applied by the other carrier.
Other Carrier: Reason Code		Enter the reason code used for a denial, as submitted on the other carrier's EOB.
Credit COB to Line Items: Line		Select the line number to access line information for this claim.
Credit COB to Line Items: Paid		Enter the primary carrier's paid amount that is applied towards the claim in the COB processing routine.
Credit COB to Line Items: Allowed		This field is only used when the **COB Calculation Method** selected in the COB Rules record found on the member's product is the higher of the two carriers' allowable amounts (H – Coordinate to the higher allowable). When used, this value identifies the primary carrier's allowable amount for the claim. Facets uses the higher of this value, or the allowable from the secondary carrier (i.e., Facets allowable in the absence of COB with primary carrier).
Credit COB to Line Items: Deductible		Enter the deductible amount applied by the other carrier for this line item.
Credit COB to Line Items: Coinsurance		Enter the coinsurance amount applied by the other carrier for this line item.
Credit COB to Line Items:		Enter the copay amount applied by the other carrier for this line item.

Field		Description
Copay		
Credit COB to Line Items: Sanction		Enter the sanction amount applied by the other carrier for this line item.
Credit COB to Line Items: Reason Code		Enter the reason code used for a denial for this line item as submitted on the other carrier's EOB.

Match UM Reviews Dialog Box (Match UM Button)

Select this option to access the **Match UM Reviews** dialog box to view and select possible UM reviews that match the line items entered for the current claim.



Completing the Match UM Reviews Dialog Box

Step		Completing the Match UM Reviews Dialog Box Procedures
Steps denoted with an * are required.		
1	*	Select a line number from the **Line** dropdown box to view the line item needed to match a UM review. The line item data displays.
2	*	Select a review in the grid in order to view a possible match for this claim. The data for the selected review displays in the text out area below the grid. Additional inpatient confinement information displays for hospital claims.

Step		Completing the Match UM Reviews Dialog Box Procedures
3	*	After finding the pre-authorization or referral review that matches the claim line, select the number of the review in the **Referral** or **Pre-auth** dropdown box along with the appropriate explanation code; this is required if a selection was made in the **Referral** or **Pre-auth** boxes in the **Match to UM Service Line** group box. The number selected in these fields can be deleted by selecting the **Clear Ref.** or **Clear Preauth** button.
4	*	Check the **Override Automated Match** checkbox to override the automated match. If this checkbox is selected, the user must select the **Display** button. The **Display Criteria** dialog box appears, which identifies the UM data that should be shown in the **Match UM Reviews** dialog box (displays below). It is completed by selecting the **From** button and entering **From/To** date information, or by selecting the **Possible Matches** or **Show All** radio button.
5	*	Select **OK**.

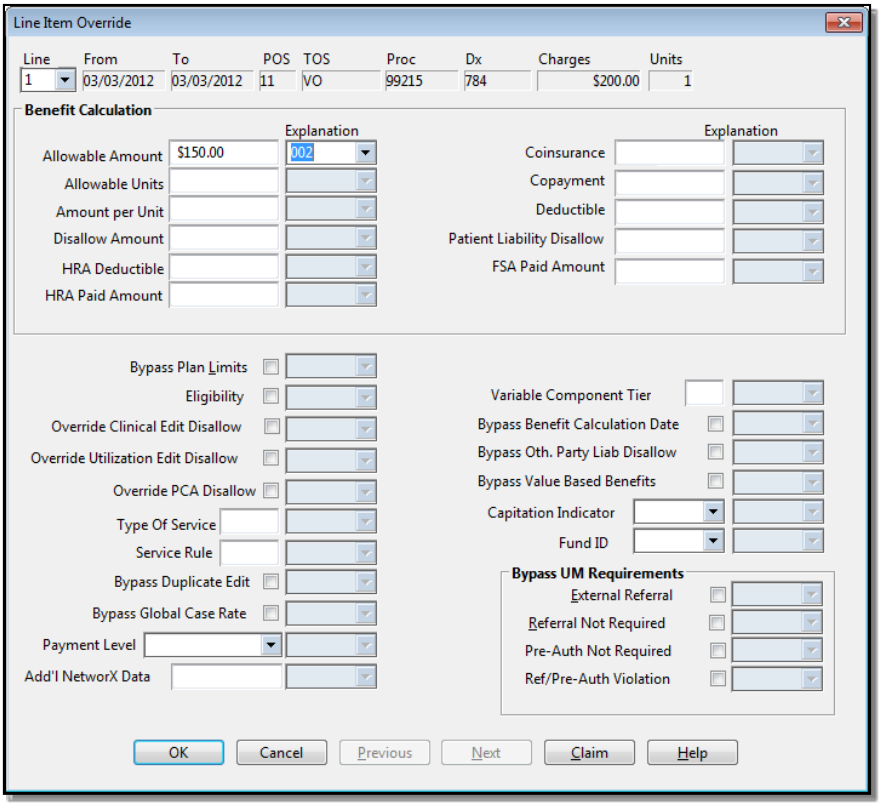
Note: When a claim matches to a UM episode for which unlimited units have been authorized, the routine that decreases UM Service Paid Units and Amounts will be bypassed. This **Match UM Reviews** dialog box will display "Unlim" (Unlimited) in the **Units** field in the grid when this situation occurs.

Override (Overrides Button)

There are two types of overrides: claim level and line item level.

Entering Overrides

Step		Entering Overrides Procedures
Steps denoted with an * are required.		
1		Select **Override…Line Item** from the **Actions** menu (**Alt+A+O+L**), the **Line Item Override** dialog box displays. This is also available through the **Overrides** button in the **Line Items** section.
2		Select **OK** when done entering overrides. **Note:** For each override selected, the user must enter an **Explanation** code.



Field		Description
Fields denoted with an * are required.		
Line		Select the claim line item to which this override applies.
Allowable Amount		Enter the value identifying the amount associated with this line override, which overrides all pricing calculations used to produce an allowable amount and will be used as the base to apply benefits.
Allowable Units		Enter the value identifying the number of units associated with this line item override. This ignores service rule counter limits and requires an amount per counter override.
Amount per Unit		Enter the value identifying the amount per unit associated with this line override that is used in conjunction with the **Allowable Units** override to manually set the total allowable amount per counter for the line. This amount is multiplied by the number in the **Allowable Units** field to calculate a total line item allowable.

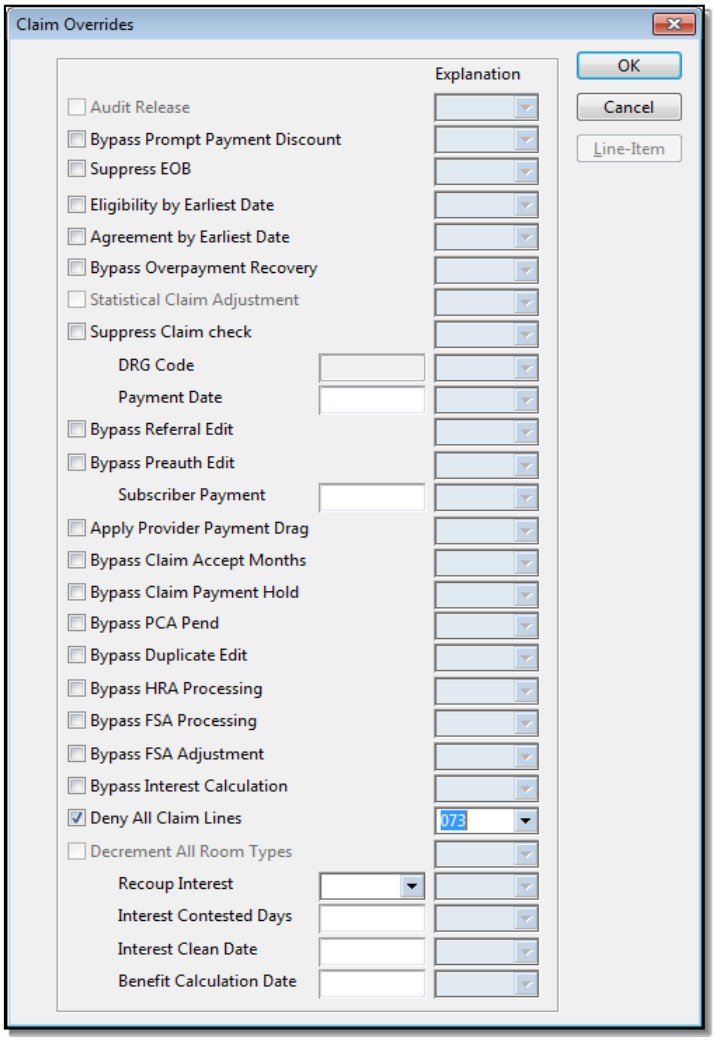
Field		Description
Disallow Amount		Enter the value of the total dollar amount disallowed for this line item override. Facets uses this as the total disallow.
HRA Deductible		Enter an amount to override the HRA deductible for this line that cannot exceed the HRA considered charge; if this occurs, an error displays. This override supports requirements for a High Deductible Health Plan (HDHP). The HRA deductible override type is DH and displays in Claims Inquiry, **Overrides–Line Item** section tab.
HRA Paid Amount		Enter a value to override the calculated value for the HRA line.
Coinsurance		Enter the value identifying the dollar amount to be applied as coinsurance associated with this line item override. This amount will be used to update member/family accumulators.
Copayment		Enter the value identifying the dollar amount to be applied as a copay associated with this line item override. This amount will be used to update member/family accumulators.
Deductible		Enter the value identifying the dollar amount to apply as a deductible to the line amount. This override ignores previously calculated deductibles and uses the override amount to up-date accumulators.
Patient Liability Disallow		Enter a value in this field to override the value calculated by a Patient Liability Extension for **Patient Liability Disallow**.
FSA Paid Amount		Enter a value to override the calculated value for the FSA line.
Bypass Plan Limits		Check this box to bypass all plan limits for this line. The resulting calculation updates accumulators. The user must enter the allowable units for claims or UM services for this override.
Eligibility		Ignore all eligibility-related disallows.
Override Clin. Edit Dis.		Bypass all non-reformatting clinical edit disallows.
Override Util. Edit Dis.		Bypass utilization edit disallows.

Field		Description
Override PCA Disallow		Select this checkbox to override a line item denial generated by the Processing Control Agent. An interest **Override Type** of PA – Override PCA Disallow is available in the **Override Type** field on the **Explanation Code** dialog box in the Explanation Codes application, Application Support application group.
Type of Service		Enter the type-of-service code associated with this override. Facets recalculates line benefits based on the code entered (found on the Product's Service Payment record).
Service Rule		Enter the service rule associated with this line override. Facets recalculates line benefits based on the rule entered. This override may be used along with the service code override and does not need to reside on the Service Payment record.
Bypass Duplicate Edit		Check to bypass duplicate disallow edits for the line item.
Bypass Global Case Rate		Check to bypass global case pricing and price using normal pricing that would have occurred if the line was not denied for service dates falling in the date range of a global pre-auth.
Payment Level		Select the payment override for this line. This points the line to a different PDVC (Product Variable Component) row.
Add'l NetworX Data		Select to allow additional reimbursement for devices associated with a surgical procedure, e.g. implants. These amounts will be returned by the NetworX*Pricer* in this field and mapped to the CDOR override table. **Note:** This is also used to store combined charges and an explanation code (PXT) that must be used to indicate the purpose of the override; to combine charges.
Variable Component Tier		Enter the variable component tier value to be applied to this line item **Note:** The **Explanation** code **Override Type** (found in the Explanation Codes application, Application Support application group) for the **Variable Component Tier** override is TR – Variable Component Tier.
Bypass Benefit Calculation		Check to bypass the admission date at the line item level. When this is selected, the line processes

Field		Description
Date		according to benefits and eligibility in effect as of the date-of-service, not the admission date.
Bypass Oth. Party Liab Disallow		Select this box to override the other party liability disallow to pay this claim. With this, the line will not be disallowed automatically when Other Party Liability was selected in the **Conditional Eligibility** dialog box of Subscriber/Family.
Bypass Value Based Benefits		This checkbox allows users to indicate that Value-Based Benefit processing should not occur for this line item; the Value-Based Benefits routines will be bypassed. **Note:** The **Override Type** of VB – Bypass VBB Parms is available in the **Override Type** field on the **Explanation Code** dialog box in the Explanation Codes application found in the Application Support application group. **Note:** This override is available to only those users who have purchased the Facets Value-Based Benefits Solution.
Capitation Indicator		Select a value to override the derived **Capitation Indicator**, making a payable claim unpayable (capitated), or a capitated claim payable. It is strongly suggested that users identify a **Fund ID** override in conjunction with the **Capitation Indicator** override; both pertain to capitation.
Fund ID		Select a Fund ID to override the derived Fund ID. This override pertains to capitation.
Bypass UM Req.: External Referral		Bypass referral only violations when a referral has been obtained and documented from an external source.
Bypass UM Req.: Referral Not Required		Check to bypass the requirement (found on the product structure) for obtaining a referral for this line item. This line item will be treated as if no referral is required.
Bypass UM Req.: Pre-Auth Not Required		Check this box to bypass the requirement (established in the member's product) for obtaining a pre-auth. for this claim line. This line will be treated as if no pre-auth. is required.
Bypass UM Req.: Ref/Pre-Auth Violation		Check this box to bypass the referral or pre-authorization requirements for this line item and pay as a violation.

Note: For faster processing of multiple overrides, the claims processing applications allow the cursor to return to the previously used override field when reviewing line items. When using the **Next** or **Previous** buttons to review line items, Facets automatically places the pointer/cursor in the override field that was applied for the edited line item. For example, if the user assigns a value in the **Amount per Unit** field, enter an **Explanation** code and select the **Next** button to edit the next item on the claim; the cursor is placed in the **Amount per Unit** field for the next line item.

Step		Entering Overrides Procedures (continued)
Steps denoted with an * are required.		
3		From the **Line Item Override** dialog box, select the **Claim** button to access the **Claim Overrides** dialog box. Overrides here pertain to the entire claim.
4		Enter the appropriate overrides with an **Explanation** for this claim.



Field		Description
Fields denoted with an * are required.		
Audit Release		Check this box to remove the payment drag assigned by audit functionality and release benefits in the next batch cycle. **Note:** This field is disabled unless the claim has been selected for audit. When a claim has been selected for audit, but not reviewed, the **Payment Date** override will be unavailable.
Bypass Prompt Payment Discount		Check this box to suppress prompt payment discounts applicable to this claim.
Suppress EOB		Check this box to suppress the printing of an EOB (Explanation of Benefits) associated with this claim.
Eligibility by Earliest Date		Check this box to use the member's earliest eligibility date.
Agreement by Earliest Date		Check this box to request Facets to bypass an error condition when line items span an agreement. Facets will process the claim based on the earliest agreement date.
Bypass Overpayment Recovery		Check this box to suppress the automatic recovery of an overpayment for the claim.
Statistical Claim Adjustment		Check this box to bypass the generation of all batch payment data for the claim. This is available only for paid claims with a status of 02. **Note:** If the user selects this override, Facets suppresses the generation of all payment data.
Suppress Claim check		Check this box to suppress the generation of a check for this claim. The user may not suppress checks to be paid to an alternate payee.
DRG Code		Enter the DRG (Diagnosis Related Group) code used to calculate the allowable amount when adjudicating the claim. This code overrides the DRG entered for the current claim.
Payment Date		Enter the date this claim will be adjudicated using this override.
Bypass Referral Edit		This functionality bypasses any referral requirement and processes all claim lines with the "Not Required"

Field		Description
		variable component row.
Bypass Preauth Edit		This functionality bypasses any pre-authorization requirement (except when the required pre-authorization was obtained) and processes all claim lines with the “Not Required” variable component row.
Subscriber Payment		Enter the amount of subscriber payment for this claim.
Apply Provider Payment Drag		Check this box to apply payment drag information found on the servicing provider’s agreement.
Bypass Claim Accept Months		Check this box to bypass the claim accept months parameters established at the plan level and provider agreement level, and release benefits for this claim.
Bypass Claim Payment Hold		Check this box to override claims payment holds for this claim. Claims overridden with this override will bypass claims payment hold parameters and adjudicate in the next batch unless subsequent pend conditions or Processing Control Agent criteria exits.
Bypass PCA Pend		Check this box for Facets to bypass the pend status placed on this claim in the Processing Control Agent application.
Bypass Duplicate Edit		Select this box to allow Facets to override a duplicate claim at the claim level. This takes precedence over a line item duplicate override.
Bypass HRA Processing		Select this if Facets should process the claim without applying HRA considerations.
Bypass FSA Processing		Select this if Facets should process the claim without applying FSA considerations.
Bypass FSA Adjustment		Select this checkbox to bypass the FSA adjustment when the current date is greater than the end of the run-out period; i.e. the user may override FSA payments on adjustments after the run-out expires.
Bypass Interest Calculation		Select this checkbox to exclude the current claim from interest calculation logic even though the product identifies interest should be applicable. **Note:** Users may manually select this option, or Workflow can be used to route claims and pass the override back to Facets automatically. The override type is BI – Bypass

Field		Description
		Interest Calculation.
Deny All Claim Lines		Check this box to deny all line items associated with the claim. **Note:** This override will be applied after eligibility is checked during claims adjudication. Therefore, the claim will be denied for eligibility first, if none is present. If eligibility is present but the **Deny All Claim Lines** override option is applied, all other claim adjudication conditions will be overridden.
Decrement All Room Types		Select this box to have Facets apply used days from all room types even if the room types identified on the claim do not match the room types identified on the UM confinement. This override allows room types that are pre-authorized in Prospective UM to match the room type value identified on the claim. **Note:** The UM product parameter **REQ_RTYPE**, **Require Room Type** in Prospective UM, must be set to Y (Yes).
Recoup Interest		Select the option to indicate how interest is to be included in the overpayment calculation (on a claim-by-claim basis): • None – Recoup interest on an overpayment only if the adjustment results in a payment to a different provider or LOB. • Yes – Recoup interest on an overpayment. • No – Do not recoup interest on an overpayment. If Yes or No is selected, that value displays on the **Overrides – Claim** section tab of Claims Inquiry.
Interest Contested Days		During interest calculation processing, this entry is subtracted from the calculated interest days when determining whether interest applies and, under which claim interest rates tier it falls.
Interest Clean Date		Enter the interest clean date for this claim. This entry will override the received date for this claim.
Benefit Calculation Date		Determine the date to use for benefit processing. To pay a claim that spans multiple calendar years, enter the low service date. If **Use Admit Date for Hospital Processing** is chosen on the Administrative Information Component for this member's product, this field displays the admission date. The eligibility, pricing, and payment are calculated based on this date.

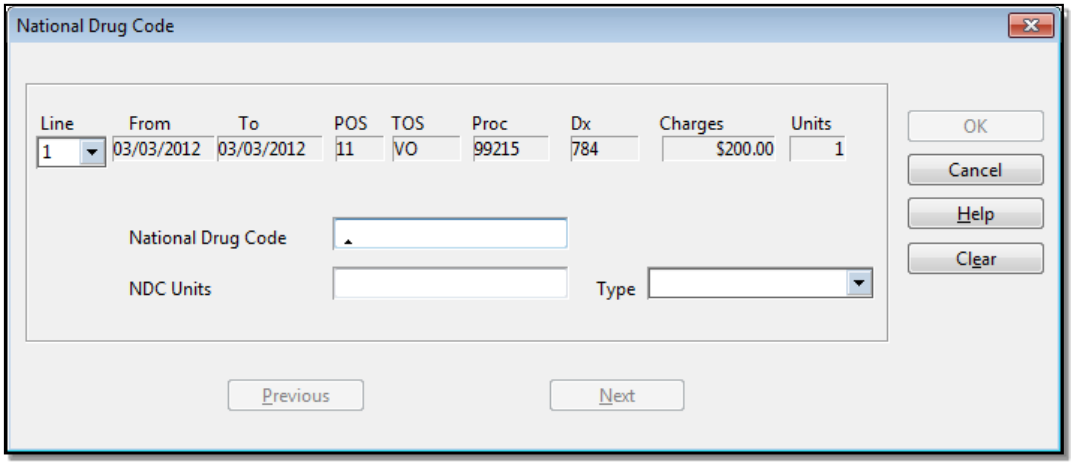
Note: For each override selected, the user must enter an **Explanation** code.

Step		Entering Overrides Procedures (continued)
Steps denoted with an * are required.		
5		Select **OK** when done entering claim level overrides with an **Explanation**.

National Drug Code Dialog Box

Medical Claims Processing supports pricing based on National Drug Codes (NDC). The NDC is priced through pricing methods established in the NetworX application group and then captured in Facets. NDC processing occurs in online claims processing only; electronic claims submissions do not pass NDC data electronically.

In the **National Drug Code** dialog box, the user selects the line item row to which the NDC applies. Facets displays the **From** and **To** service dates, place of service, type of service, procedure code, diagnosis code, line charges and the number of requested units for that line. In addition, if NDC pricing is used, the user is required to enter a 15 digit NDC in the **National Drug Code** field. This field automatically adds dashes after the first five digits and after the next four digits. The number of NDC units is also required. The user is to enter the amount of units, pills, packs, or dosage in the **NDC Units** field. A whole or partial unit using a decimal code may be entered. The **Type** field allows the user to store the type of measurement for a drug; it is required.



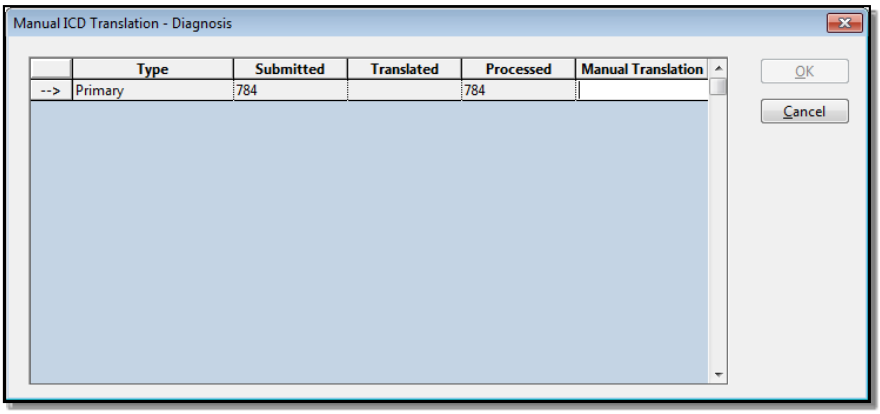
The **Line Items** section tab of the Medical and Hospital Claims Processing applications displays the line item level NDC data entered. The **Line Item Details** section tab of the **Medical** section in the Claims Inquiry application displays the same information.

Manual ICD Translation – Diagnosis Dialog Box

Users may manually translate ICD procedure and diagnosis codes on claims due to one of three potential reasons:

- Mapping for a submitted code is not indicated in the TriZetto ICD Translation Manager
- Multiple mapping rows exist for a submitted code in the TriZetto ICD Translation Manager and the user desires the ability to select one
- The user disagrees with the mapping generated by the TriZetto ICD Translation Manager

In Medical Claims Processing, selecting **Manual ICD Translation** from the **Actions** menu opens the **Manual ICD Translation - Diagnosis** dialog box (see below), which displays all diagnosis codes for the claim, along with their submitted and translated values. In Hospital Claims Processing, this menu option opens a submenu with two options: **Diagnosis** and **Procedure**. Users may select to open the M**anual ICD Translation – Diagnosis** dialog box or the **Manual ICD Translation – Procedure** dialog box. Depending on security authorization, users may manually enter a new code to overwrite the displayed code. Entries made in this dialog box will display in the **Translated** fields in the claims applications.



The **Manual ICD Translation – Diagnosis** dialog box displays all of the claim level diagnosis codes by Type (e.g., Primary, Secondary, etc.). For each diagnosis code, the Submitted, Translated, and Processed codes display.

Note: These fields are for display only and cannot be changed.

Users may manually translate a code by entering a new code in the **Manual** translation field. The new manually entered code will replace the derived diagnosis code. Facets logic will confirm that the entered diagnosis code is valid, and that the ICD version for the translated code is appropriate. An error message displays if the code is not found or if the ICD version is incorrect. If the translated code is being used for processing, the original processed code will also be replaced.

Note: Once an entry has been made, the claim must be reprocessed.

Facets will also determine if any primary diagnosis codes entered at the line item level match any claim level diagnosis codes for which manual determination has been made. If any are found, the line item primary diagnosis code will be replaced as well.

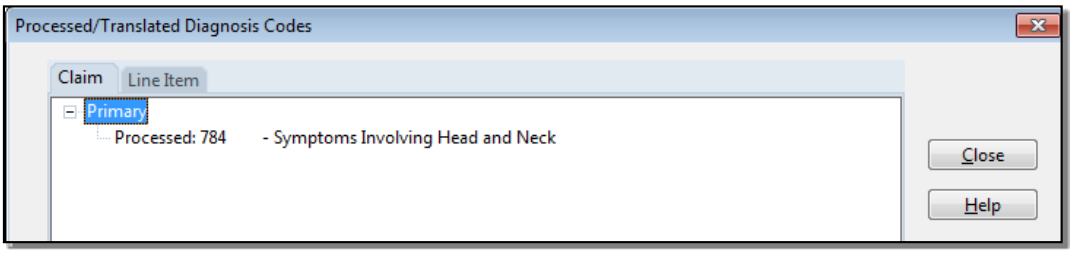
If the translated code is not being used for processing, the processed codes will remain as originally derived and only the translated codes will be replaced.

In Hospital Claims Processing, the **Manual ICD Translation – Procedure** dialog box displays all claim level procedure codes by Type (e.g., Primary, Secondary, etc.). For each diagnosis code, the **Submitted**, **Translated,** and **Processed** codes display.

View Menu Option: Processed/ Translated Codes

Select this option to open the **Processed/Translated Diagnosis Codes** dialog box to review the Diagnosis Set and diagnosis codes at the claim and line item level.

Note: This menu option is available only when a claim has been processed.



The **Claim** tab displays the claim-level diagnosis codes and the **Line Item** tab displays the line item-level diagnosis codes. Select the **+** sign to view the processed and translated codes and their descriptions.

Note: The message “Manual” displays for any manually translated code.

Claim Segments

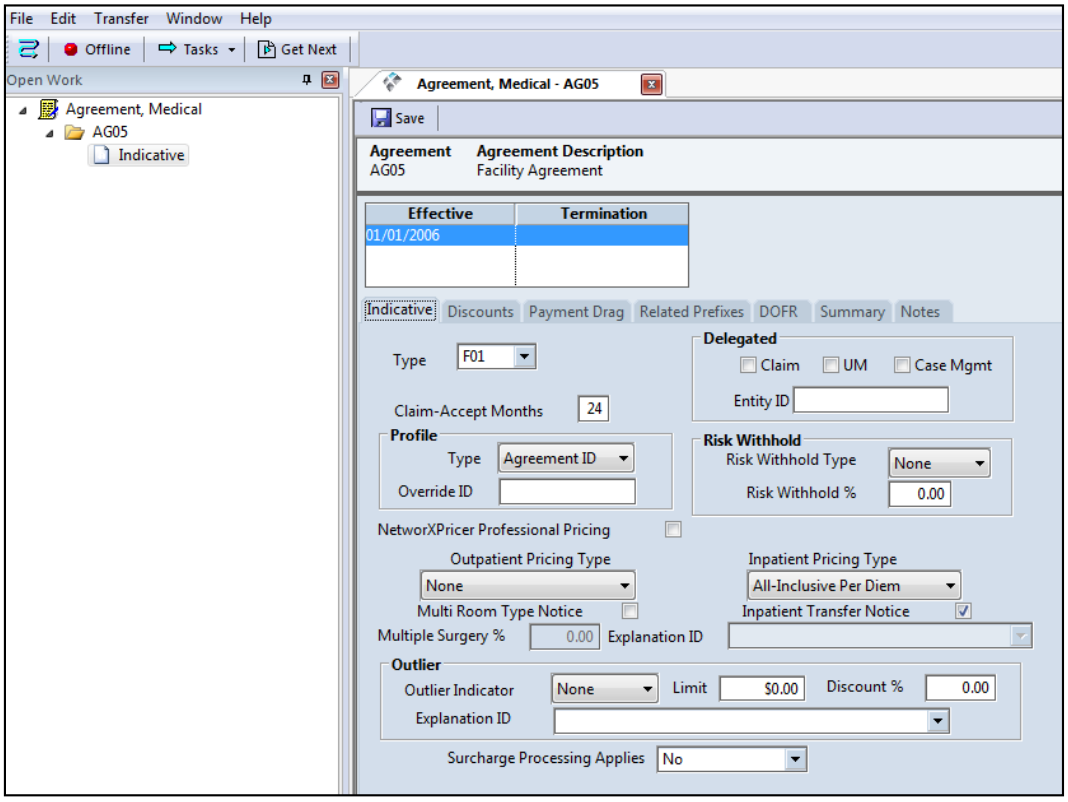
Claim No.	Segment	Status	Save	Batch Run	Segment	Status	Comment
0123456789	00		Yes			01	While in a 01 status, the claim can be recalled and changes can be made to it.
0123456789	00	01		Yes	00	02	Payment Batch Cycle is completed. The 01 status claim changes to a status 02.
0123456789	00	02	Yes		00	91	The 02 status claim is changed (a.k.a. an adjustment) and saved. This claim becomes a 91 status keeping history. A new 01 segment is created, with the new information.
0123456789	01	01	Yes				
0123456789	01	01		Yes	01	02	Payment Batch Cycle is complete, the 01 status claim changes to a status 02.
							And this can continue for 98 more segments.

Changing a claim status

Step		Changing a claim status
Steps denoted with an * are required.		
1	*	Open the claim and enter the appropriate changes.
2	*	Select **Process** from the **File** menu or select **F3** to adjudicate the claim. Once the claim is reprocessed, the claim's prior status will be updated and changed to the desired status.
3	*	Select **Save** from the **File** menu and assign a status: Select **Accept** (**F4**) or **Accept/Continue** (**Shift+F4**). To place an incomplete claim on hold, select **Pend** (**F5**) or **Pend/Continue** (**Shift+F5**).

Hospital Pricing: All Inclusive or R&B Per Diem/Per Case

In the **Indicative** section tab of the agreement, identify a profile using the **Type** field (and the **Override ID** field, as needed). If Agreement ID was selected for the **Type**, the same prefix used to identify the agreement also identifies the Room Type Profile.



Two dropdown fields (**Outpatient Pricing Type** and **Inpatient Pricing Type**) need to be completed if outpatient and/or inpatient services listed on the Service Definition will price using "All inclusive or R&B per diem / per case" pricing. Both fields will indicate the type of pricing Facets performs for inpatient and/or outpatient services.

Five options are listed in the dropdown for both of these fields that work in conjunction with the "All inclusive or R&B per diem/per case" **Pricing Method** that is indicated on the Service Pricing record. They are as follows:

- Per Diem/Per Case: A roll-up is done. The **Category** field on the Room Type Profile determines if pricing is based on per diem or per case for each line.
- Per Case (All Inclusive): A roll-up is done to the R&B service. The price is based on per case pricing.
- Per Case (Non Inclusive): No roll-up is done. Pricing is based on per case for each line on the claim.

- All-Inclusive Per Diem: A roll-up is done to the R&B type of service. The price is based on per diem.
- R&B Per Diem: No roll-up is done even if there is an R&B type of service on the claim. The price is based on per diem pricing.

Use a Room Type Profile record to associate **Room Type** codes with prices, and indicate if the price should be calculated on a per diem or per case basis (indicated by the **Category** field on the Room Type Profile).

Use the **Indicative** section tab of the Room Type Profile to identify the **Room Type** with a **Category** (per diem/per case), an **Effective Date**, and if necessary a **Termination Date**, discount and risk sharing information is also included. Use the **Pricing Tiers** section tab to associate a number of units with a price that will be calculated based on what was indicated in the **Category** field and the option selected in the **Inpatient** and/or **Outpatient Pricing Type** fields on the agreement.

Note: Pricing can be tiered using the **Pricing Tiers** section tab.

Room Type Description Application (Application Support Application Group)

Use this application to segregate the creation of customizable (user-defined) room types. It allows users to define room types and associate them internally with standard, hard-coded classifications through an optional Room Type Indicator parameter. Additionally, the standard rate at which a particular room type is reimbursed may now be overridden within the Room Type Profile application (see below). This is done by assigning the Room Type an Alternate Room Type parameter. The **Room Type** value/field in this application is the assigned ID for the room type, while the (Room Type) **Description** field describes the Room Type value created. The **Room Type Indicator** field allows the user to determine whether the **Room Type** value is for a private room, semi-private room, or a case room (e.g. Maternity), and will enable the user to classify his/her created room types.

An **Auto Room Type** record should be created from the Medical Provider Agreement application group that will be used to relate services to a specific room type code, and will in turn relate the service to a price. An Auto Room Type record is created using a **Prefix** and a **Service ID** (TOS).

The same prefix is used for each service code on the Service Definition that points to a Service Pricing record with a pricing method of “All inclusive or R&B per diem / per case” pricing. The **Type** for this pricing method should be “Room and Board”.

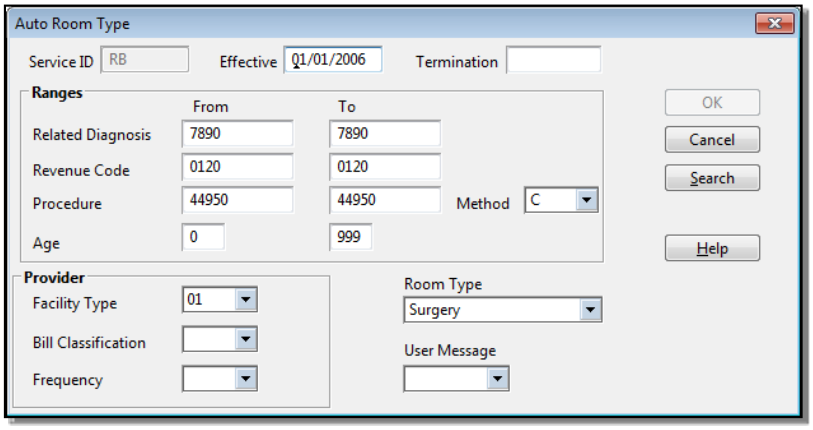
This prefix created to identify the Auto Room Type record should be added to the **Related Prefixes** section tab of the medical agreement under the **Type** of AGRT.

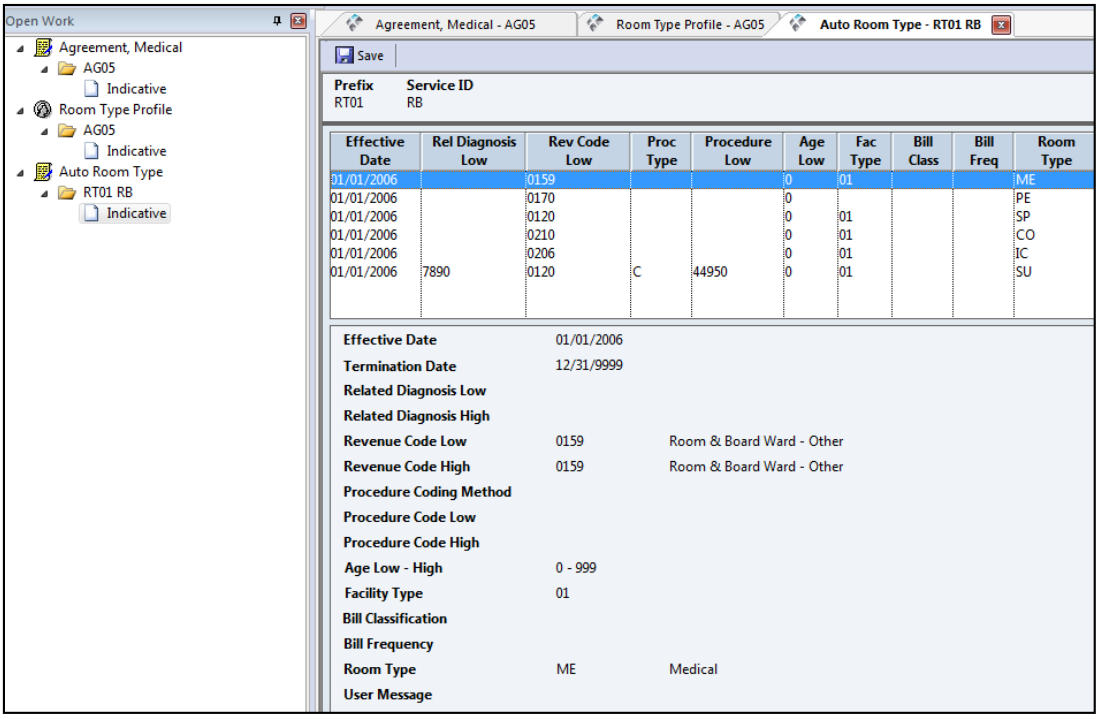
Auto Room Type Application (AGRT)

The Auto Room Type identifies the room type entry that is required to obtain pricing values for All Inclusive Room and Board and Per Diem and Per Case hospital priced claims. This prefix is attached to the provider's Agreement in the **Related Prefixes** section tab. During claims processing, the room type is automatically generated based on criteria entered in the application. Once the room type is found, Facets will then determine the correct pricing values for the room by using the Room Type Profile Application.

Indicative Section

Use this section to establish auto room type parameters such as diagnosis, revenue and procedure codes, age, and class of bill. Select a row in the grid to view details in the scrollable text-out area below the grid.





Note: Instead of using an Auto Room Type record, a room type code can be entered manually on a claim. This practice leaves a large margin for user error and also eliminates the option of automatic adjudication for hospital claims.

Room Type Profile Application

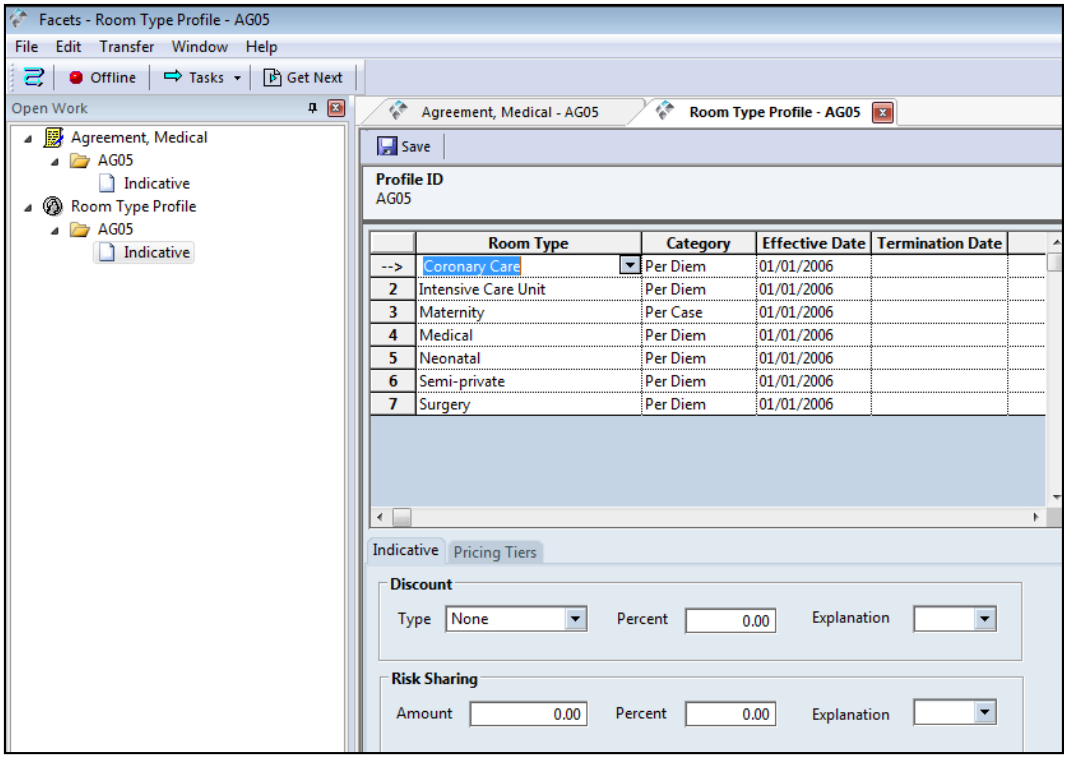
The Room Type Profile application is used when the medical plan calculates benefit and room rates based on per diem and/or per case information. This application will identify the different room types, the rate for each room, and how that rate should be calculated (per diem / per case) in relation to the number of units identified on a claim line.

Indicative Section

The grid at the top of this section will display the Effective and Termination dates for a rate/discount, a Category selection (identifies how Facets, based on units, will calculate the rate), and the actual room type (user defined). This section includes two section tabs: **Indicative** and **Pricing Tiers**.

Indicative Section Tab

Use this section tab to define the information used to calculate any discount associated with a particular room type.



Field		Description
Fields denoted with an * are required.		
Room Type	*	Select the value (user defined) that identifies the hospital room. For example, MA for Maternity or PY for Psychiatric.
Category	*	Select whether this Room Type is linked to per diem or per case pricing.
Effective Date	*	The date the per diem or per case pricing/discount went into effect.
Termination Date		The date the per diem or per case pricing/discount was terminated.
Alt. Room Type		Selection list (scroll across). Use this field to set an alternate benefit rate for a given user-defined room type that will be accessed during claims processing. It enables core Facets users to classify room types, as well as provides the ability to price private rooms at a semi-private room rate. Additionally, the use of this field is optional for core users. During claim adjudication, if the alternate room type were used, it would apply to a claim line where the alternate room type label is

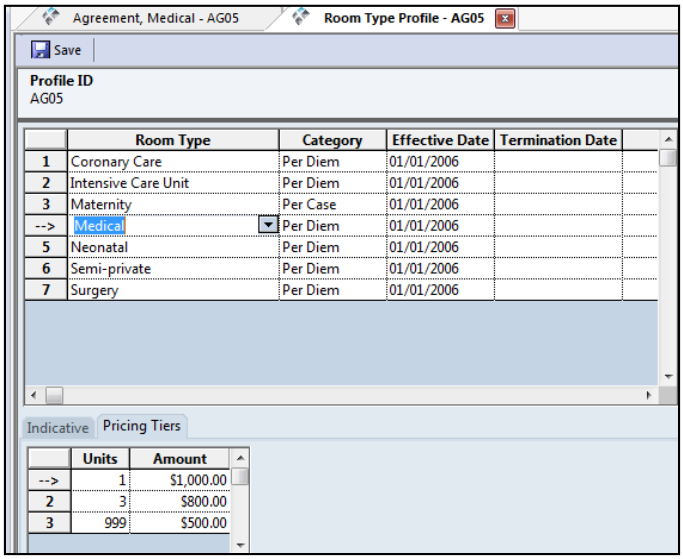
		populated in the **Line Items** section of the Hospital Claims Processing application. If not set manually, this value will default to the original room type value when claims are processed. The standard rate at which a particular room type is reimbursed may be overridden within this application, which is done by assigning the Room Type an Alternate Room Type parameter in this field. **Note:** The user with the appropriate level of security may transfer to the Room Type Description application (found in the Application Support application group) via the **Transfer** menu option to add or update room types.

More information can be found in the Medical Provider Pricing Profile guide.

Pricing Tiers Section Tab

This section tab defines the information used to calculate the rates associated with a particular room type. If different rates are to be priced for a room type (e.g., $250/per day for the first 2-days of a confinement stay and $200 thereafter), then multiple tiers may be entered.

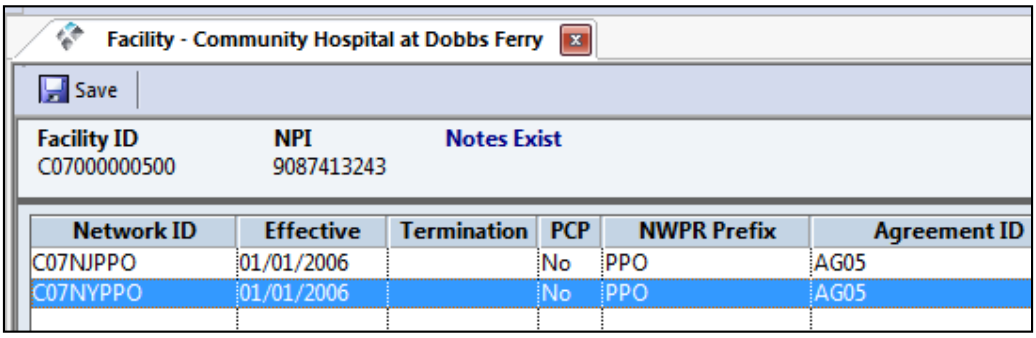
Note: In order for Facets to properly recognize the unit entries, these entries must be in ascending order.



Field		Description
Fields denoted with an * are required.		
Units	*	Enter the allowable units for a specific rate that will be

		used in calculating a price for the room type selected in the top grid.
Amount	*	Enter the allowable rate that will be used in calculating a price for the room type selected in the top grid.

Add the agreement to the provider's (facility's) **Networks** section of their Facility application.

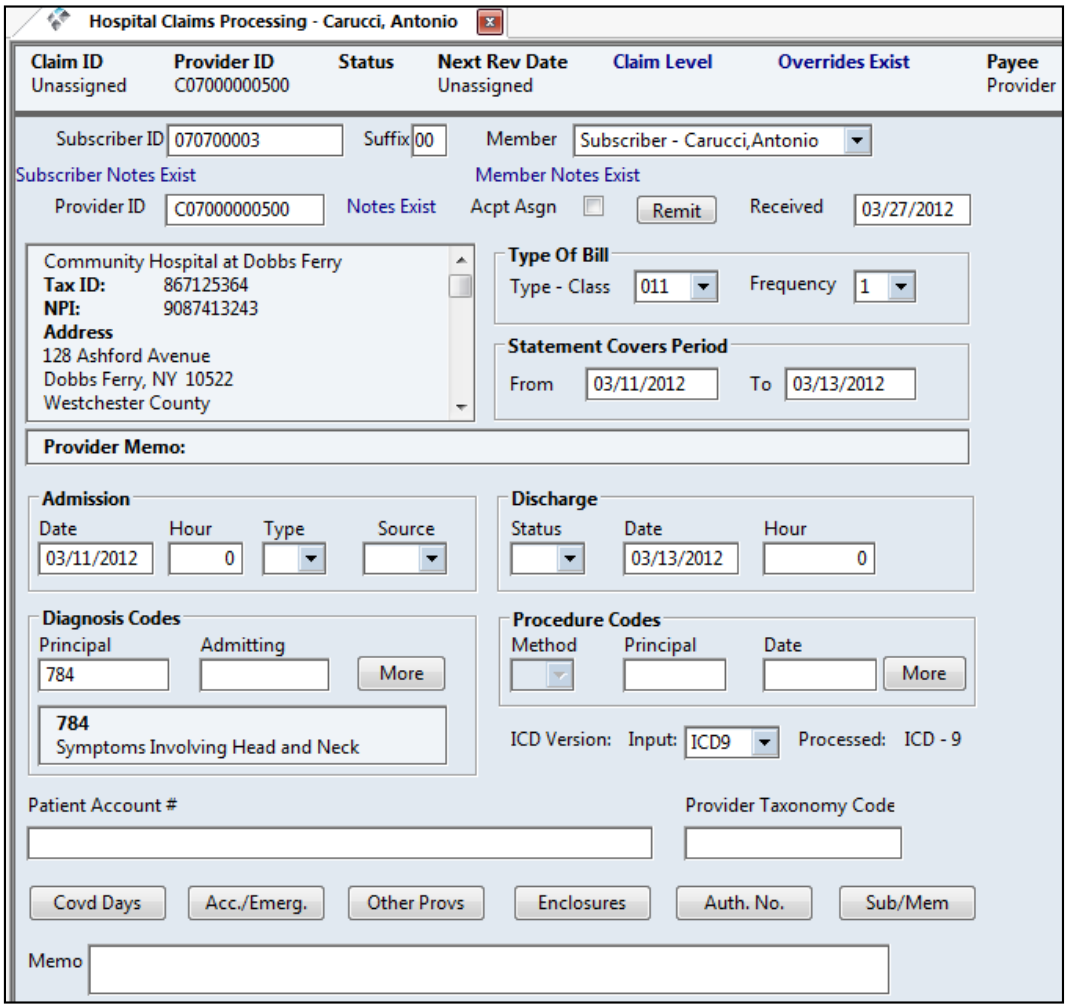


Hospital Claims Processing Application

This application allows the user to process hospital claims.

Indicative Section

This section identifies the subscriber, provider, diagnoses, and patient account information. Facets checks eligibility-based information entered here.



Fields common to claims processing applications are described in detail in the Medical Claims Processing Field Descriptions table.

Field/Button		Description
Fields denoted with an * are required.		
Acpt Asgn		Select this checkbox if the provider accepts Medicare reassignment. This field is informational only if the **Medicare Limiting Charge** field is set to "Not Applicable" in the Service Pricing application.
Type & Class of bill	*	Select a type of bill from the dropdown; e.g. Hospital Inpatient.
Frequency		Indicate the frequency of the bill, i.e. interim, admit-discharge, etc.
Statement Covers Period: From date To date	*	Enter the earliest thru the latest date of claim data.
Admission Date, Hour, Type, Source		Enter the admission date, time and type (e.g. emergency, elective, etc.)
Discharge Status, Date and Hour		Select the patient's status at the time of discharge. The user may also select the date and time of discharge. **Note:** When the **Inpatient Transfer Notice** checkbox on the Agreement, Medical application has been selected, Facets displays a warning message when a patient is transferred to another inpatient facility with a discharge status of 02 (Discharge/Transfer: Other Inpatient Facility), 04 (Discharge/Transfer: ICF), or 05 (Discharge/Transfer: Cancer Center or Children's Hospital).
Principal Diagnosis Code	*	Up to 10 characters. Enter the principal diagnosis code.
Admitting Diagnosis Code		Up to 10 characters. Enter the admitting diagnosis code.
More button		This option allows the user to enter up to 24 additional diagnosis codes, as well as **External Cause of Injury** codes (**E codes**). This button supports diagnosis

Field/Button		Description
		codes that come in electronically based on the 837 ANSI X12 standard version 5010 claims and encounter transactions for health care professional, institutional, and dental claims.
Procedure Code Method		This is the procedure coding method. **Note:** This field is disabled, as the data is no longer available on the UB-04 claim form.
Principal Procedure Code		Enter the standard procedure code for this procedure.
Date of procedure		Enter the date the procedure was performed.
More button		Use this button to access the **Procedure Codes** dialog box. The user may enter up to 24 additional procedure codes associated with the admission and the date each one was performed. **Note:** If a procedure code is entered, a date is required.
Covered Days button		In this dialog box, enter the number of days that are eligible and medically necessary within a hospitalization for this member (informational only).
Other Providers button		Use this to document any other providers related to this claim. Providers must use a single National Provider Identifier (NPI) value for health claims. A claims processor may search for a provider's NPI when searching for the provider's ID through this button. NPI is a search option found in the **Search** dialog box. The provider's NPI displays in the **Provider Details** section tab of the **Line Items** section. Also, Facets letters and reports display of the provider's NPI.
Auth. No. button		Document a referral or a pre-authorization number assigned to this claim by another source. This number is for informational purposes only.

Hospital Admit / Discharge Date Warnings

Procedures can be performed outside the range of the entered **Admit** and **Discharge** dates. A warning message displays and the claim can be processed without pending.

Claim Level Procedure Codes: The following warning message will display: 175 – Procedure Code Date outside Admission/Discharge Date Range.

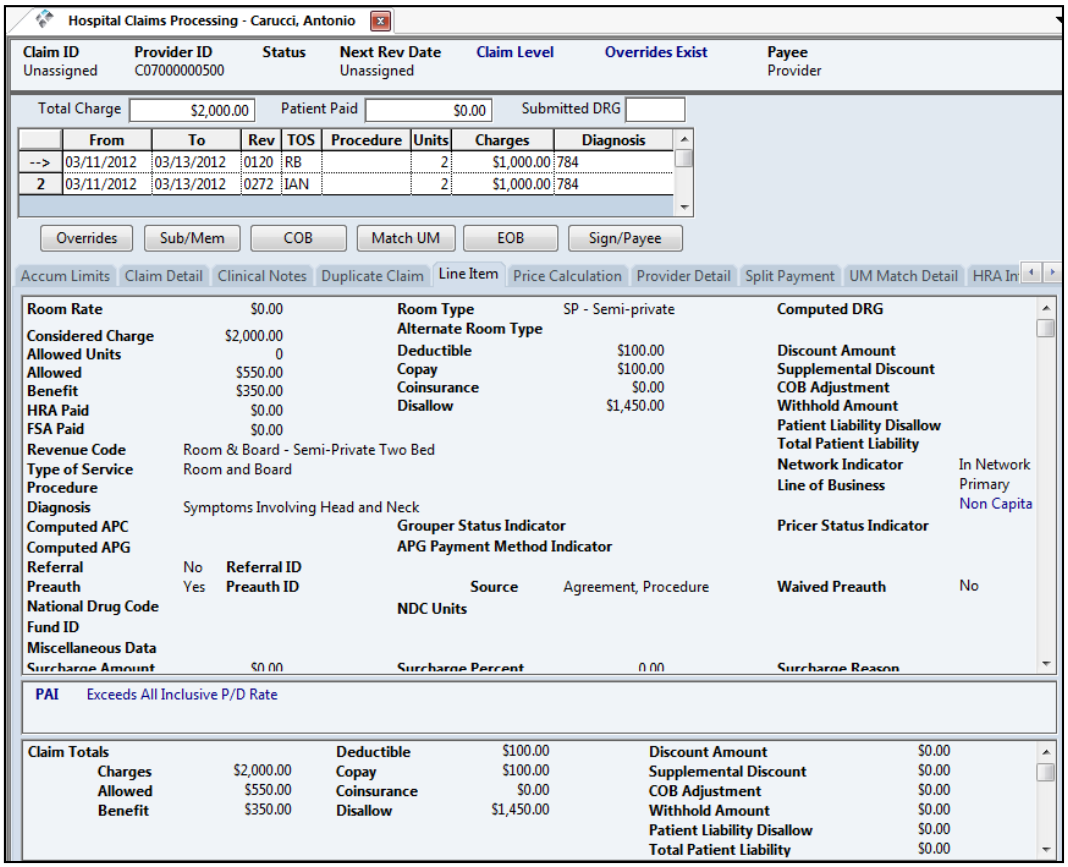
Line Level Dates of Service: The following warning message will display: 174 – Service From Date is Less Than Admit Date.

Users may also enter line items with **From** dates that fall prior to the **Statement From** date on an outpatient claim. The following warning message will display: 177 – Service From Date is Less Than Statement From date.

Note: It is possible the procedure dates are in one year while the **Admit** and **Discharge Dates** are in a different year. This is acceptable; an error message will not display.

Line Items Section

Use this to enter and view line detail for a hospital claim.



Field		Description
Fields denoted with an * are required.		
Total Charge	*	Enter the total claim charge. This must equal the total of line items.
Patient Paid		Enter the amount paid by the patient.
Submitted DRG		Enter the DRG code submitted on the claim form.
From/To	*	Enter the **From** and **To** dates relative to this line item.
Rev	*	Enter the hospital **Revenue** code, as indicated on the hospital claim form. The UB-04 committee requires all revenue codes to be 4-digits. When entering a revenue code in Facets, the user must add a leading zero to that code. Any three-digit entry will generate the following error message, Revenue Code Not Found.
TOS		Facets will populate this field if using the Revenue Code Conversion table.
Procedure		Enter the standard CPT-4 or HCPCS code for this procedure.
Units	*	Enter the number of units or counters associated with this line item (up to 9,999).
Charges	*	Enter the charges associated with this line item. The total of all line items must equal the total charges.
Diagnosis		Enter the **Diagnosis** code associated with this line item.

Note: Entering any amount of claims manually is unlimited. Facets does not restrict users from entering any amount of line items in any claims application. For electronic submissions: institutional (hospital), 837 logic will error if more than 999 line items are submitted. For dental and professional (non-hospital), 837 logic will error if more than 50 line items are submitted.

Hospital Claims Processing Section Tabs

Section tabs in the **Line Items** section provide additional information about the claim being processed, such as duplicate claim information, details about the line items, price calculation information, clinical notes that may exist, and details regarding UM reviews that match to the claim.

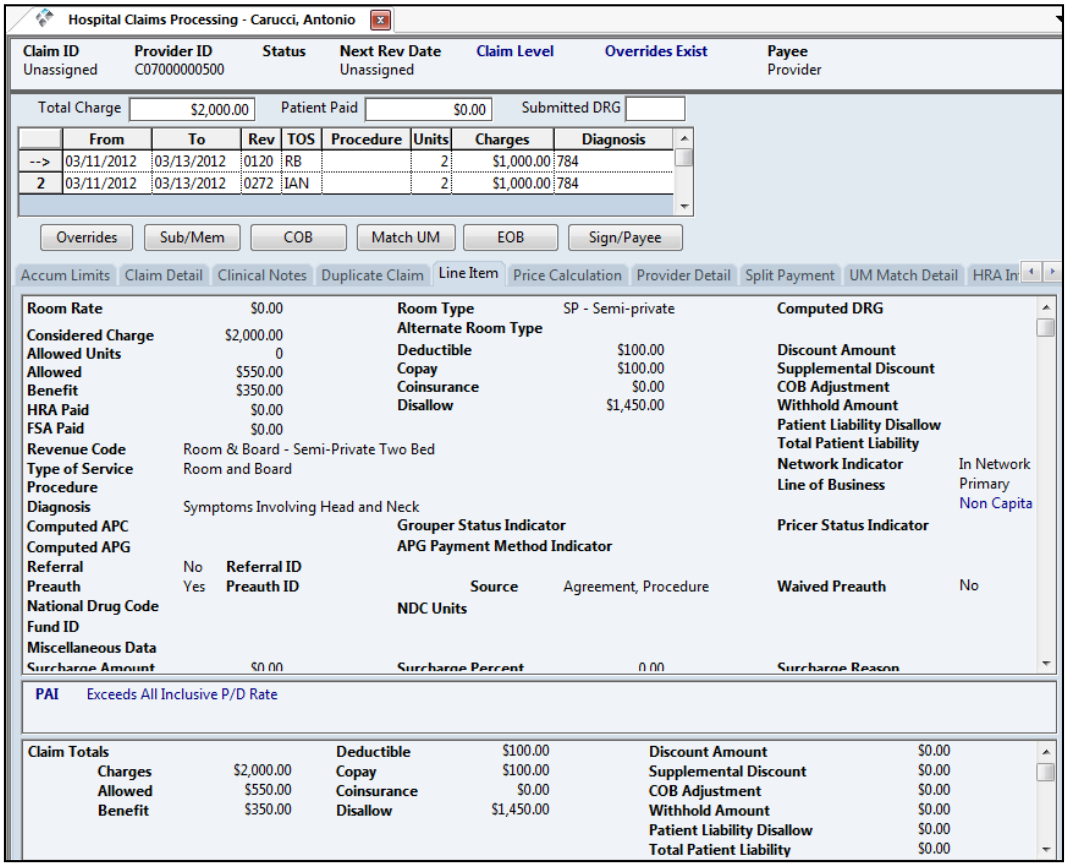
After a claim is adjudicated, the **Line Item** section tab displays first.

Line Items Section

This section contains an enterable grid in which the user may enter and view line item information for this member's claim.

Line Item Section Tab

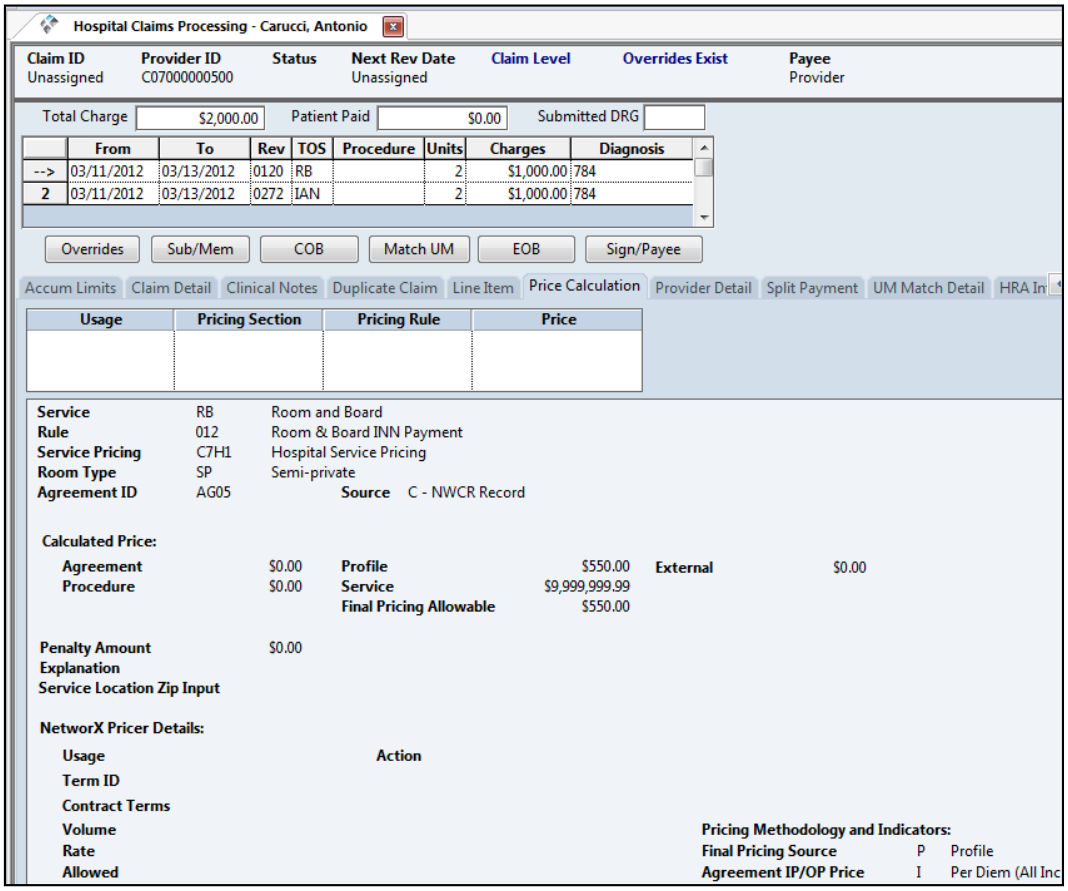
This section tab displays the adjudication episode (after selecting **F3** to process) for the line item selected. Specific data such as allowable amount, deductible, co-pay, coinsurance, disallow, COB, and benefit amounts for each line item displays. To view additional line item information for this member's hospital claim, select a line item in the grid at the top of this section and scroll through the section tabs text-out area below the section tabs.



Price Calculation Section Tab

This section tab shows pricing details, such as the **Service Rule**, **Service Pricing**, and any type of agreement or other pricing arrangements. It also displays Networ*XPricer* details, as well as the source of the price used in calculation for the selected line item. This section tab includes a grid to accommodate multiple NetworX pricing tables. Select a row from the section grid to review the price calculation and NetworX pricing details associated with that claim line.

Note: Claims priced using NetworX are bypassed instead of pended in scenarios where the NetworX module is either unavailable or fails. This allows these claims to be picked up by subsequent batch job runs once the NetworX issue is resolved.



Hospital Claims Processing Menu Options

The dropdown menus from the menu bar will also allow the user to enter additional information necessary to processing a hospital claim.

The following options may be selected from dropdown menus:

Edit Menu Option	Description
Room Rate (Alt+E+R)	To enter required room rates on a line item-by line-item basis, select this option and enter the necessary information in the **Room Rate** dialog box.
Room Type (Alt+E+T)	To enter required room types on a line item-by-line item basis, select this option and enter the necessary information in the **Room Type** dialog box.

Actions Menu Option	Description
Condition Codes (Alt+A+N)	Select this option to access the **Condition Codes** dialog box. Use this dialog box to enter condition codes that are supplied on the hospital bill form.
Diagnosis Codes (Alt+A+D)	Select this option to access the **Diagnosis Codes** dialog box and enter additional diagnosis codes (up to 17) pertaining to the entire claim.
Interim Bills (Alt+A+L)	Select this option to access the **Interim Bills** dialog box to recall a claim and continue processing interim bills under one **Claim ID**.
Occurrence Codes (Alt+A+R)	Use this dialog box to enter up to 12-occurrence codes that are supplied in sections 32 through 36 of the UB-04 hospital bill form.
Procedure Codes (Alt+A+P)	Select this option to access the **Procedure Codes** dialog box and enter additional procedure codes for this hospital claim. Complete the appropriate fields of this dialog box with the information supplied in sections 80 and 81 of the UB-04 hospital bill form.
Value Codes (Alt+A+V)	The **Codes** dialog box allows the user to identify additional values that affect the adjudication of a claim. The numbers assigned to the **Value Codes**, 39-41, correspond to the fields on the UB-04 form. The

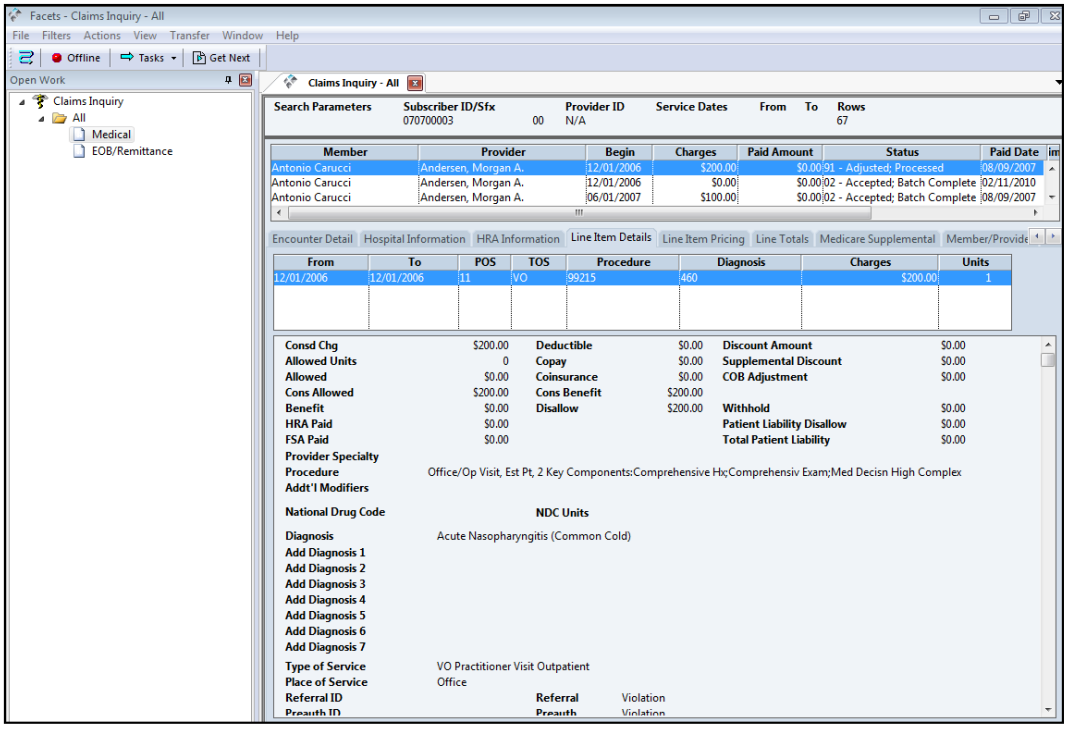
Actions Menu Option	Description
	user may enter up to four codes for each number (A-D) If the corresponding **Code** field for this line is valued with A0 (ambulance service), the user must enter the zip code for the point of pick-up in the **Value ID** field.
Other Providers	If applicable, enter the provider ID for the admitting provider, the operating provider, as well as up to two other providers associated with this member's confinement claim.
Birth Weight (Alt+A+W)	Select this option to access the **Birth Weight** dialog box and enter the patient's birth weight in grams.

Claims Inquiry Application

The Claims Inquiry application allows a user to run queries on medical, dental and FSA claims and review detailed information about these claims, including member and provider information, claim status, line item details, products and prefixes, disallow amounts, overrides, clinical edits, UM match details, batch messages, and EDI information. The user may also view the information to be printed on the subscriber's Explanation of Benefits (EOB) or provider's remittance forms.

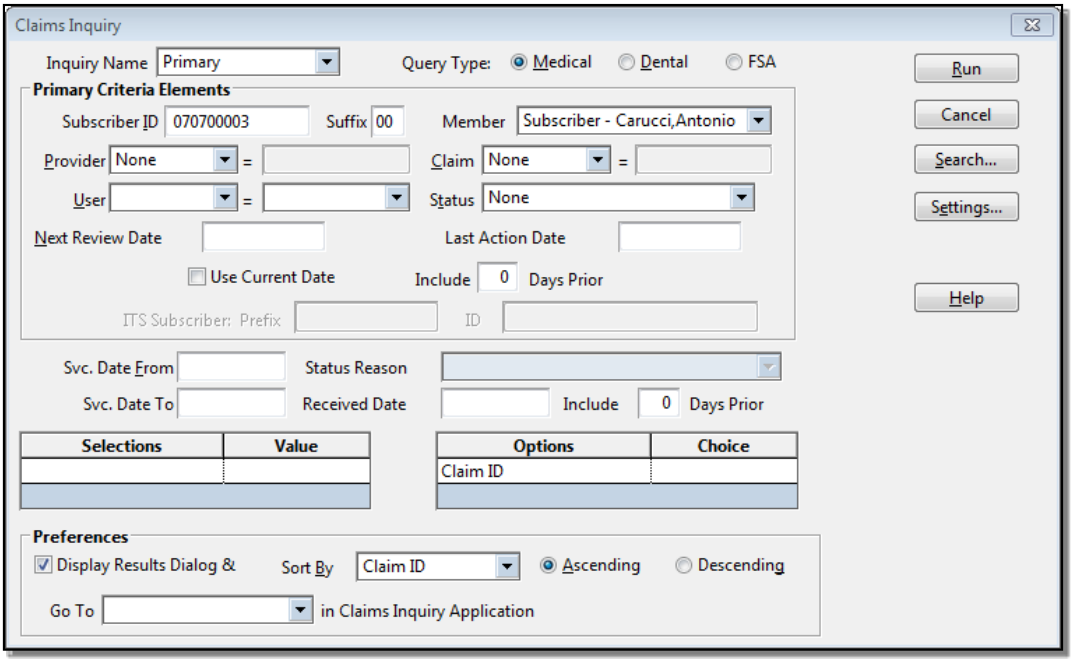
Medical Section

After successfully running a query, claim information for both medical and hospital claims is displayed in the **Medical** section.



Running a Query

Step		Running a Query Procedures
Steps denoted with an * are required.		
1		Open the **Claims Inquiry** application from the Claims Processing application group.
2		Select **F9** from the keyboard. **OR** Select **Alt+F+O+I** from the keyboard. The **Claims Inquiry** dialog box displays.

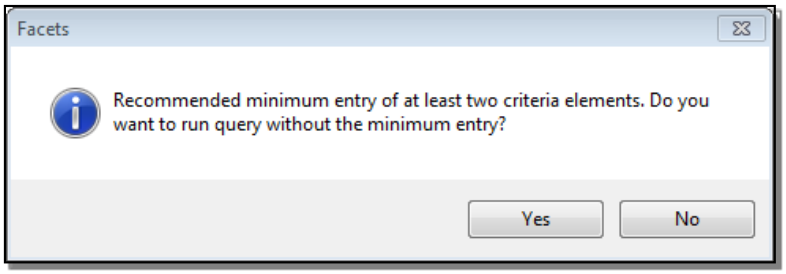


Step		Running a Query Procedures (continued)
Steps denoted with an * are required.		
3		Complete the information on the **Claims Inquiry** dialog box as described in the following field descriptions table.

Field		Description
Fields denoted with an * are required.		
Inquiry Name		Select the user-defined name of the inquiry; this is optional and created through the **Settings** button.
Query Type	*	Indicate if this inquiry is for a Medical, Dental, or an FSA query.
Primary Criteria Elements	*	Select at least one of the items listed in this section to run the inquiry/query.
Last Action Date		Enter a date to be used in conjunction with a Subscriber ID, Provider ID, and/or User ID to retrieve all claims that have already been processed based on this date. Use this criteria to retrieve a list of all matching claim numbers in sequential order.
Svc. Date From		Indicate the earliest From date-of-service.
Status Reason		Enter the code for the claim status reason.

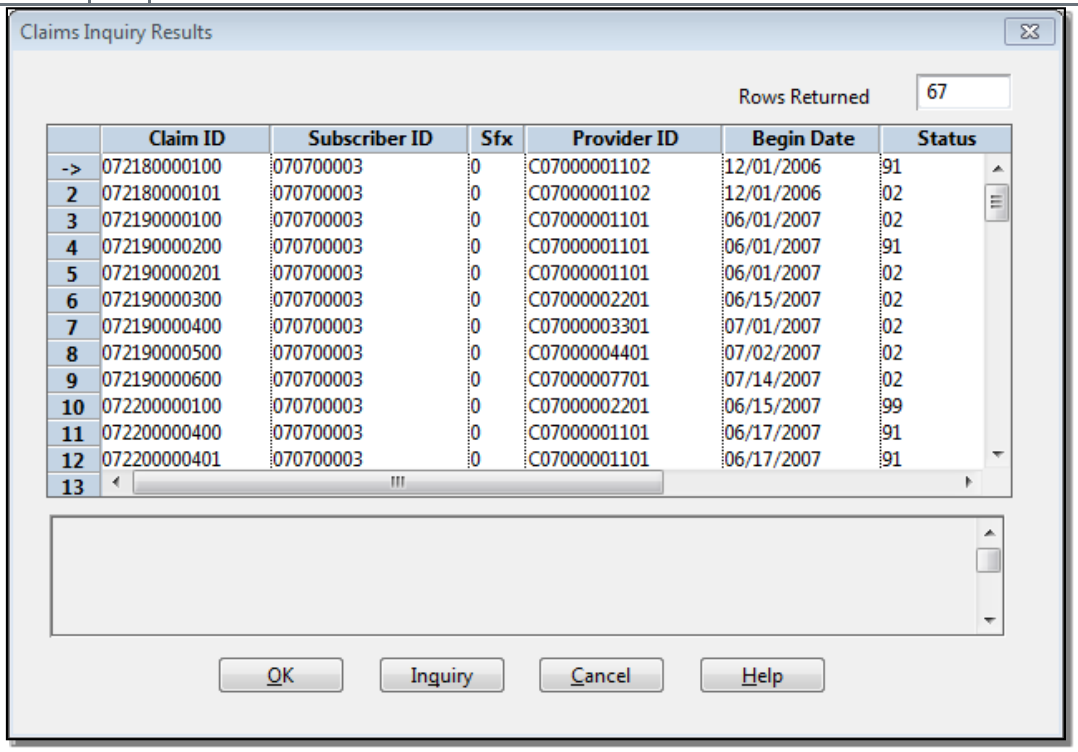
Field		Description
Svc. Date To		Enter the claim's most current To date-of-service.
Received Date		Enter the Received Date for this claim.
Include __ Days Prior		Enter the number of days to calculate a date range for the Received Date. Facets finds all claims with a Received Date in this range.
Selections/Value		Search criteria to define and indicate the value, e.g. group ID or procedure.
Options/Choice		Search criteria the user may define and indicate in the Options field, e.g. product category or input method.
Preferences: Display Results Dialog & Sort By		Select this checkbox to display the **Claims Inquiry Results** dialog box and select the 'sort' method. When selected, the radio buttons will be activated. Select Ascending or Descending.
Preferences: Go To _____in Claims Inquiry App.		The section in Claims Inquiry the user will view this information (Medical, Dental, or EOB/Remittance).

Step		Running a Query Procedures (continued)
Steps denoted with an * are required.		
4		Select the **Run** button. The query will process. If less than two Primary Criteria Elements were entered, the following dialog box displays.



Step		Running a Query Procedures (continued)
Steps denoted with an * are required.		
5		Select the **Yes** button. The query will run and the **Claims Inquiry Results** dialog box displays.

		OR Select the **No** button. The **Claims Inquiry Results** dialog box displays. If the claim desired was not listed, select the **Inquiry** button to return to the **Claims Inquiry** dialog box. Enter additional criteria or change the previously indicated criteria and re-run the query.

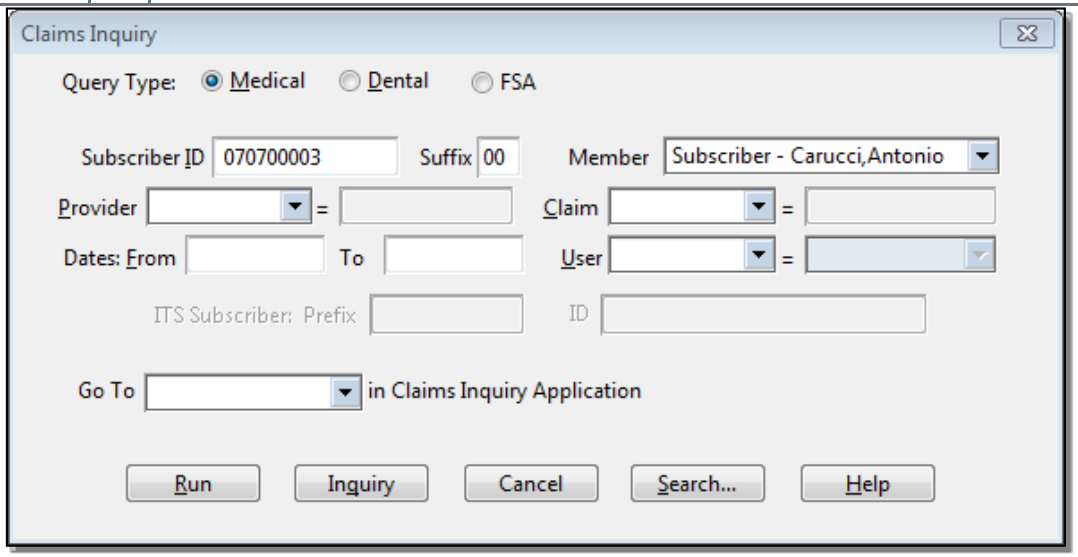


Claim ID	Subscriber ID	Sfx	Provider ID	Begin Date	Status
072180000100	070700003	0	C07000001102	12/01/2006	91
072180000101	070700003	0	C07000001102	12/01/2006	02
072190000100	070700003	0	C07000001101	06/01/2007	02
072190000200	070700003	0	C07000001101	06/01/2007	91
072190000201	070700003	0	C07000001101	06/01/2007	02
072190000300	070700003	0	C07000002201	06/15/2007	02
072190000400	070700003	0	C07000003301	07/01/2007	02
072190000500	070700003	0	C07000004401	07/02/2007	02
072190000600	070700003	0	C07000007701	07/14/2007	02
072200000100	070700003	0	C07000002201	06/15/2007	99
072200000400	070700003	0	C07000001101	06/17/2007	91
072200000401	070700003	0	C07000001101	06/17/2007	91

Step		Running a Query Procedures (continued)
Steps denoted with an * are required.		
6		Select the appropriate claim or claims to view them from the **Medical** section of the Claims Inquiry application. **Note:** If no claims are selected, all claims will display.
7		Select the **OK** button. The requested claims display in the grid at the top of the **Medical** section. When a line is selected, the claim information displays in the text-out area below. The default tab is the **Line Item Details** section tab.

Quick Inquiry

Step		Running a Quick Inquiry Procedures
Steps denoted with an * are required.		
1		Select **Alt+F9**. **OR** Select **Alt+F+O+Q**. **OR** Select the **File** menu. Select **Open**. Select **Quick Inquiry**. The **Claims Inquiry** dialog box displays.

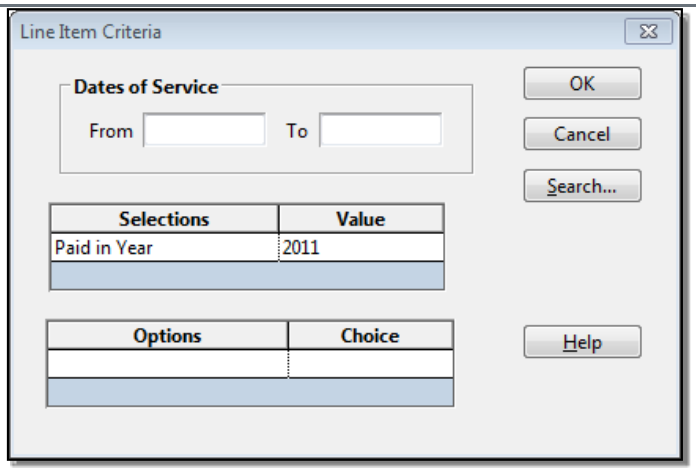


Note: See the **Running a Query** *section, Step 3* for field descriptions.

Narrowing a Search

The user may now select to further narrow the search from the claim selections displayed in the sections grid.

Step		Narrowing Search Procedures
		Steps denoted with an * are required.
1		Select **Alt+L+R**. **OR** Select the **Filters** menu. Select **Criteria**. The **Line Item Criteria** dialog box displays. This dialog box allows the user to further limit the returned claims by specifying line item elements; e.g. service dates, as well as additional Selections and Options.



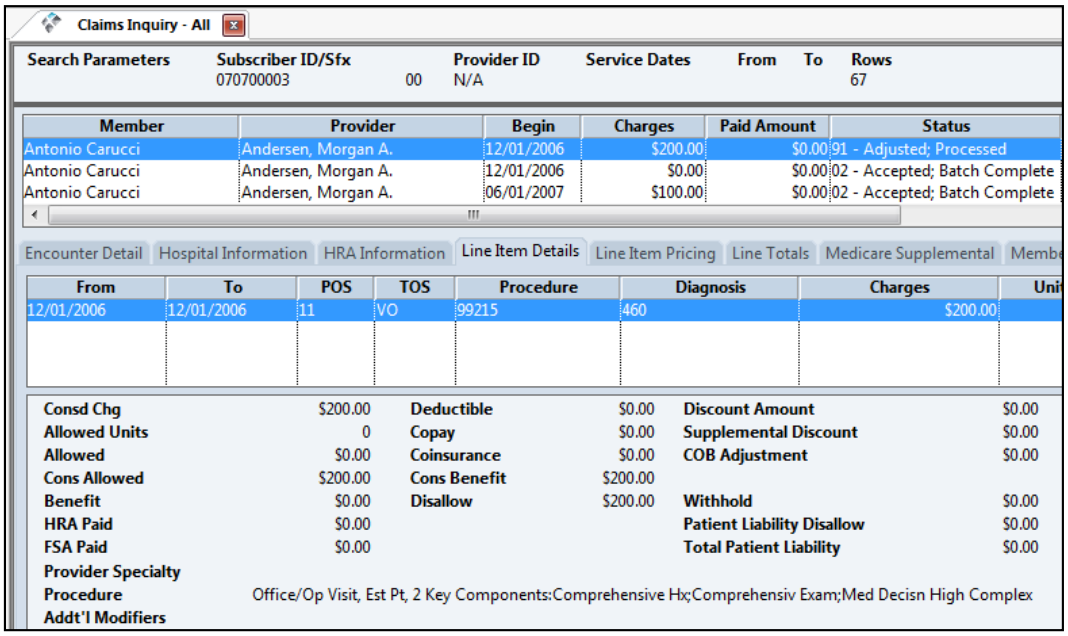
Step		Narrowing Search Procedures (continued)
		Steps denoted with an * are required.
2		Select the **OK** button. The **Medical** section displays.
3		To return to the claims originally selected: Select **Alt+L+U**. **OR** Select the **Filters** menu. Select **Undo Criteria**.

Viewing Detailed Claims Information

The user may view detailed information in the section tabs for the claims selected after running the inquiry/query.

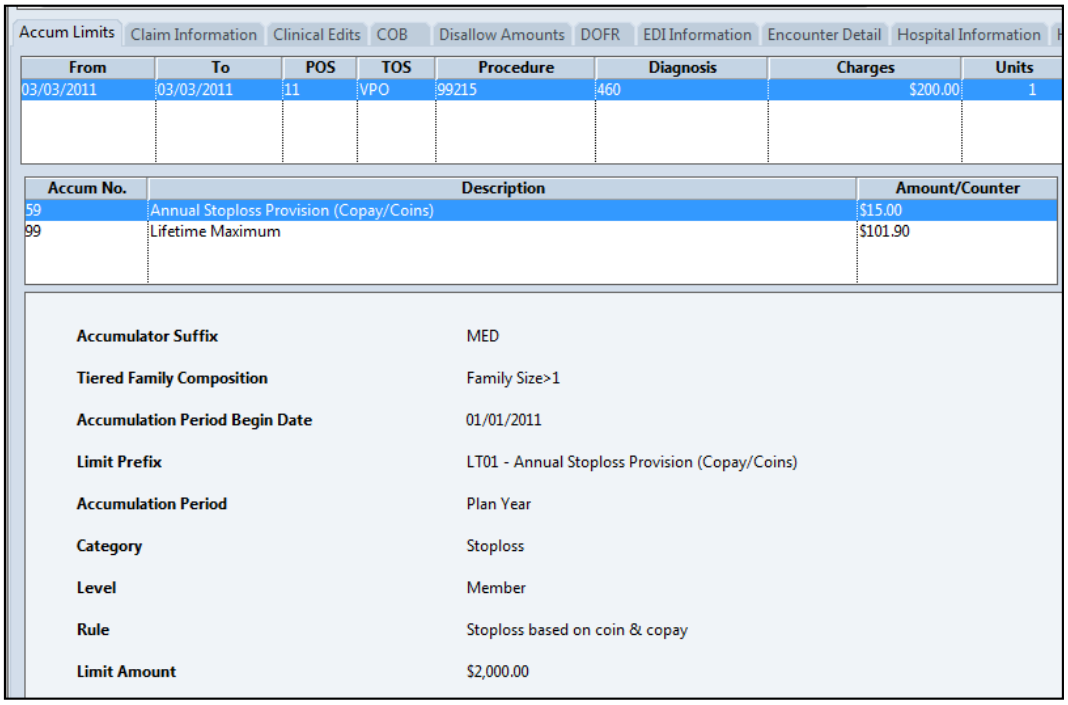
Line Item Details Section Tab (default)

The grid in this section tab displays the adjudication episode for the selected line item. Data such as the allowable amount, deductible, co-pay, coinsurance, disallow amount, additional diagnosis codes and benefit amounts for the line item selected will display in the text-out area below the grid.



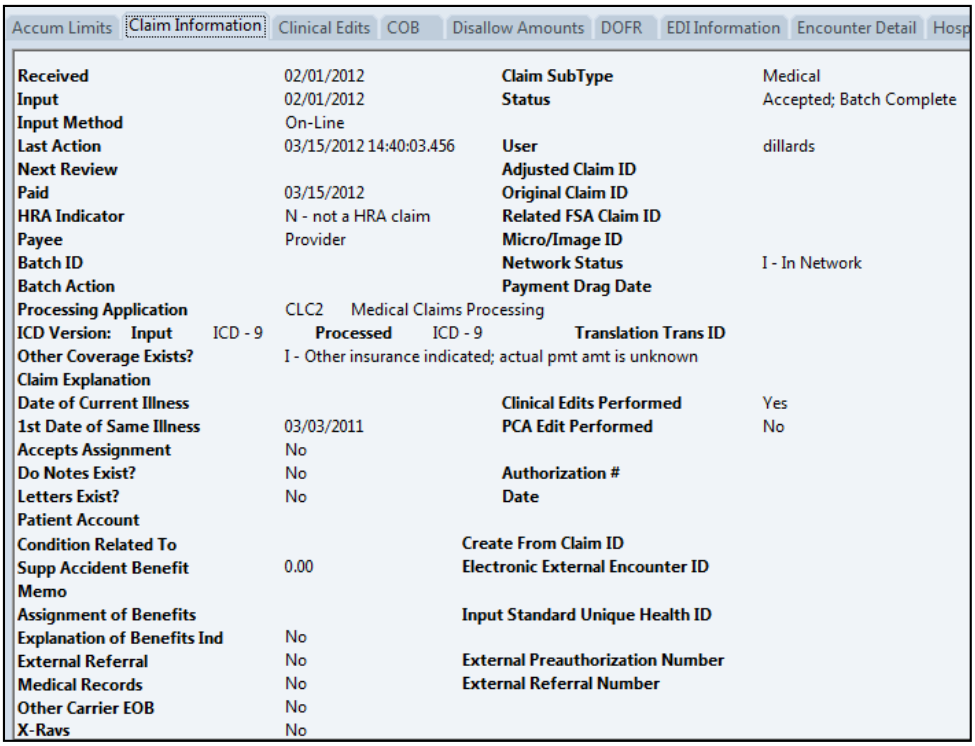
Accum Limits Section Tab

This section tab (scroll to the right) allows the user to select an Accumulator Number row in the lower grid to view line-level accumulator information in the text-out area.



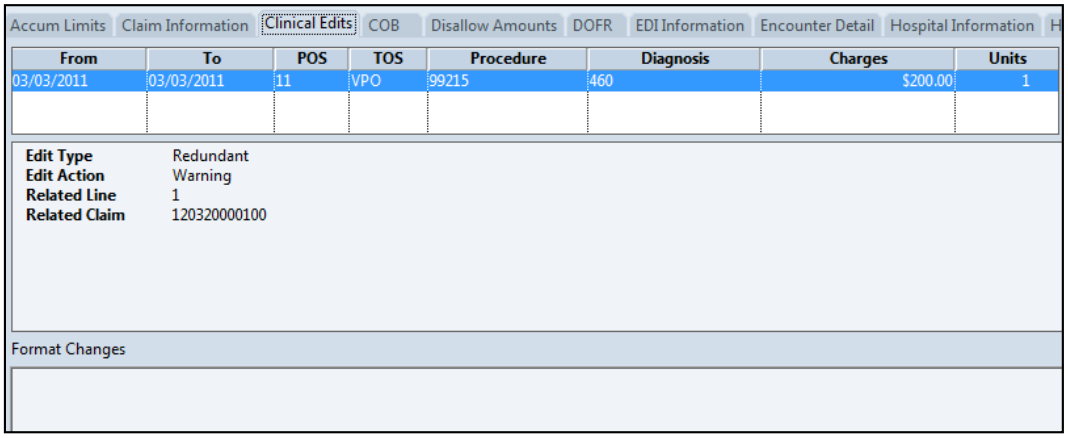
Claim Information Section Tab

This section tab displays claim adjudication information for a medical claim.



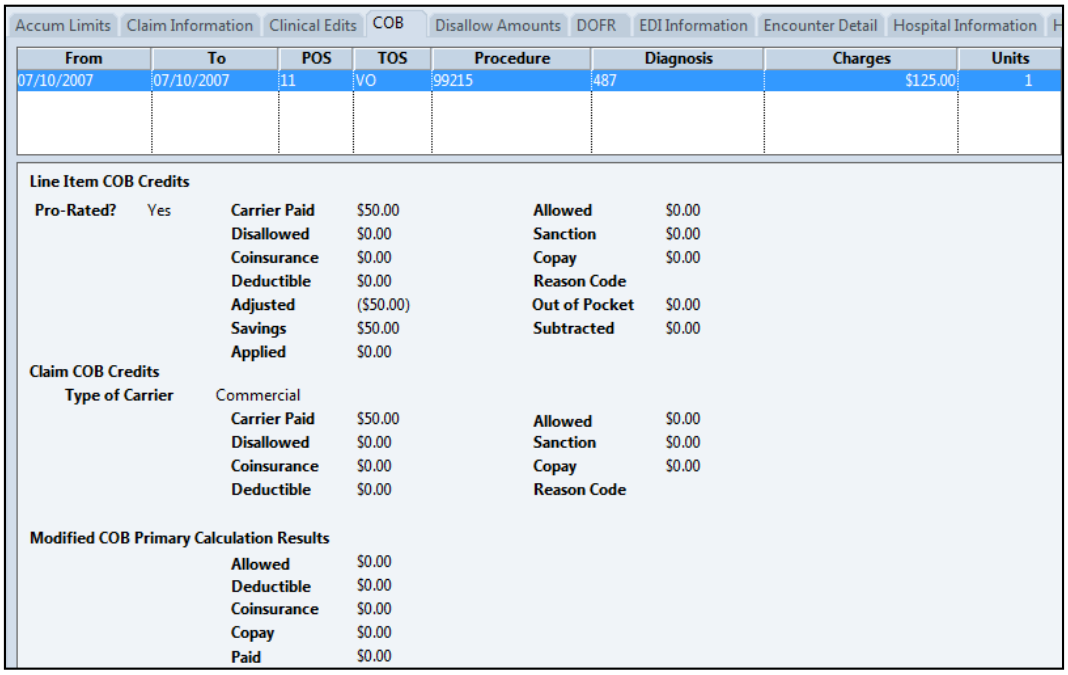
Clinical Edits Section Tab

Select a line item in this section tab to view clinical edits for that line in the grid below.



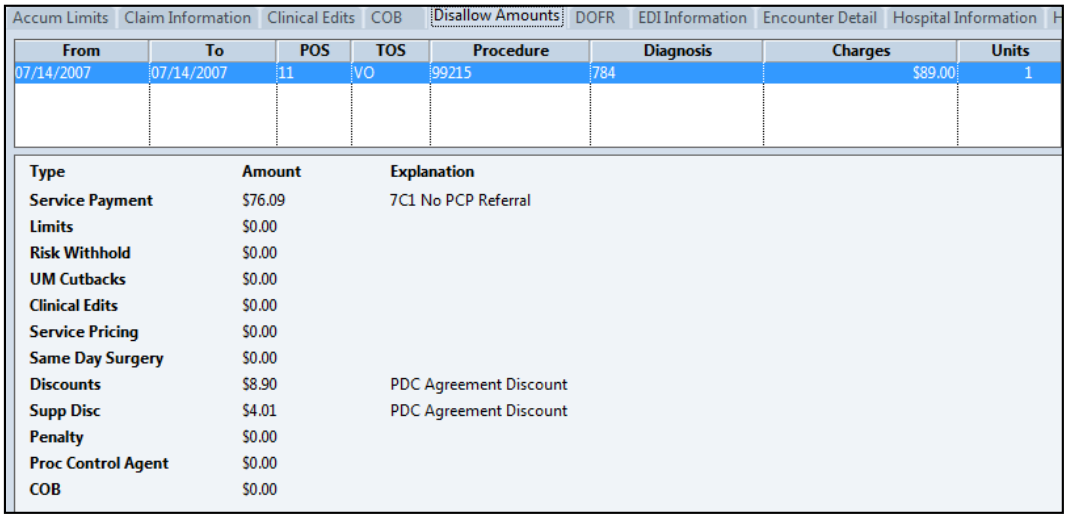
COB Section Tab

Select a line item from the grid in this section tab to view coordination of benefits information applicable to this line item in the bottom portion of the screen.



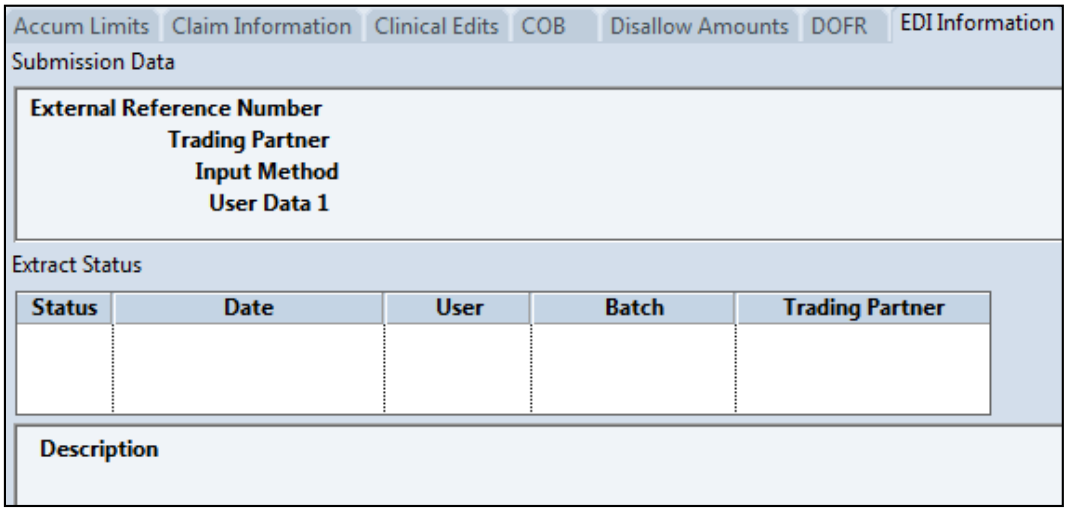
Disallow Amounts Section Tab

Select line items from the grid in this section tab to view the disallow amounts for each line item.



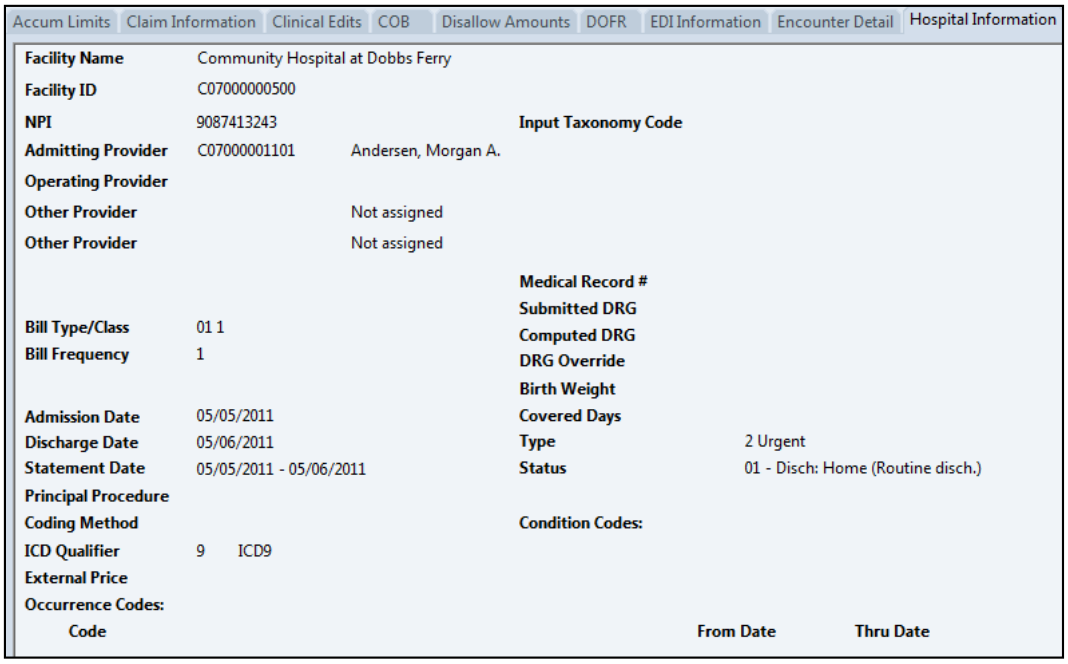
EDI Information Section Tab

The EDI Information section tab shows the external reference number and trading partner for a claim that has been submitted using the EDI subsystem.



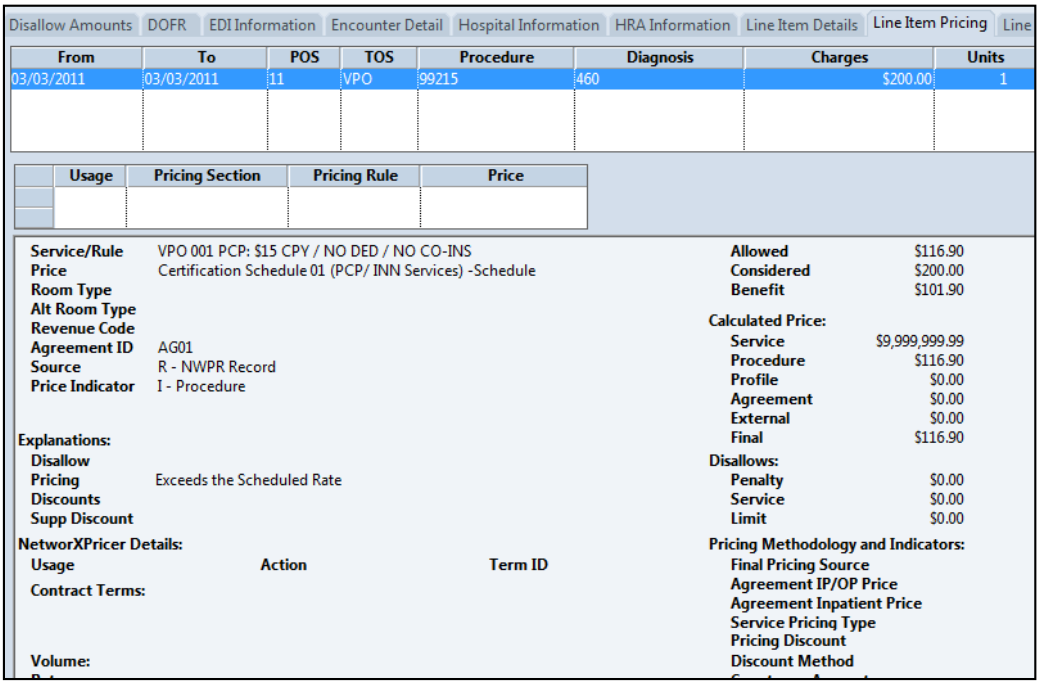
Hospital Information Section Tab

Select a line item from the grid in this section tab to view hospital information.



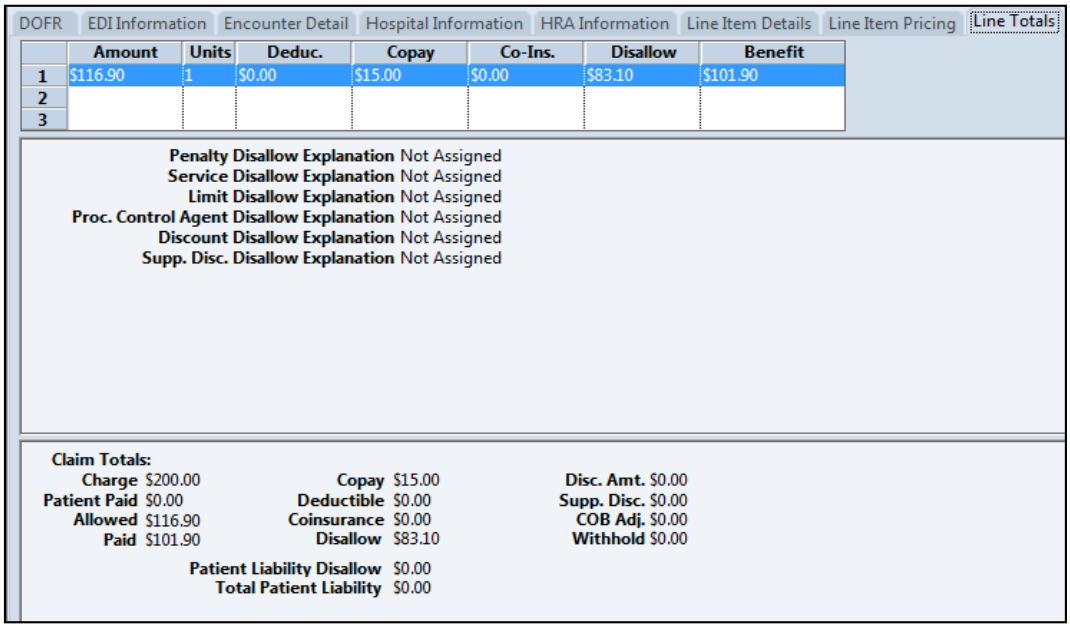
Line Item Pricing Section Tab

Select a line item in this section tab to view pricing information in the text-out area below the grid. This section tab display also includes Networ*XPricer* calculation data.



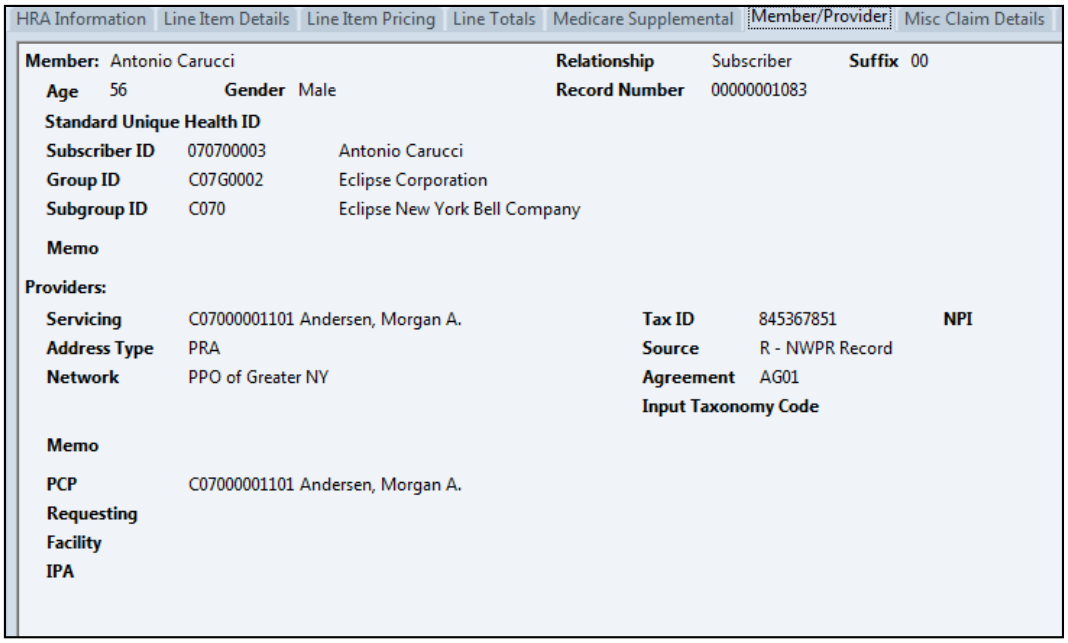
Line Totals Section Tab

This section tab displays allowed and disallowed totals for each line item associated with the selected claim.



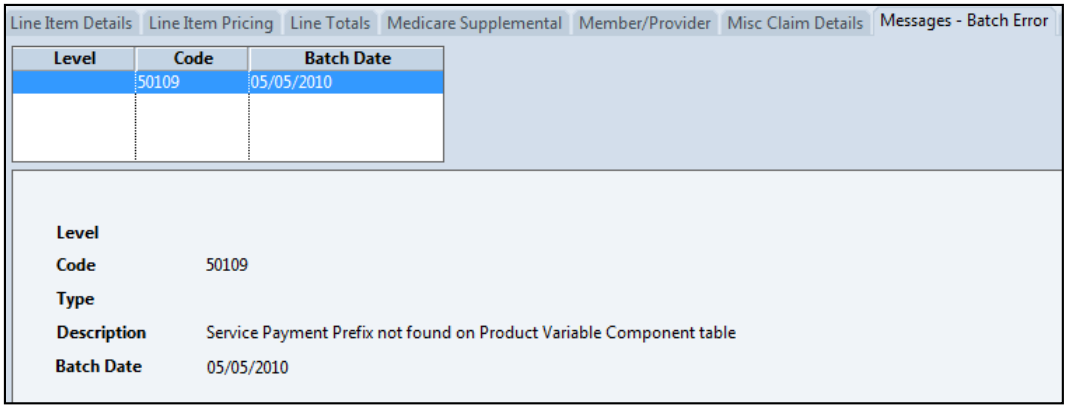
Member/Provider Section Tab

Select a line from the grid in this section tab to view member and provider information.



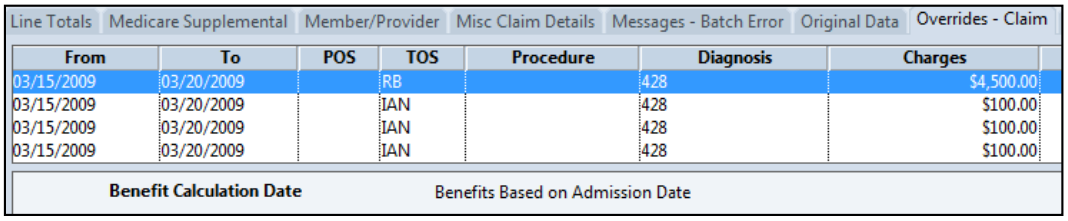
Messages - Batch Error Section Tab

This section tab shows error messages that appear as a result of the batch process for the selected line item.



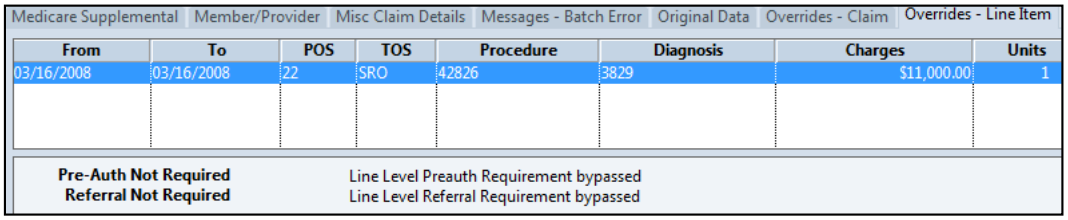
Overrides – Claim Section Tab

In this section tab, select a claim from the grid to view claim-level overrides. If no overrides exist for the claim, the text-out area will be blank.



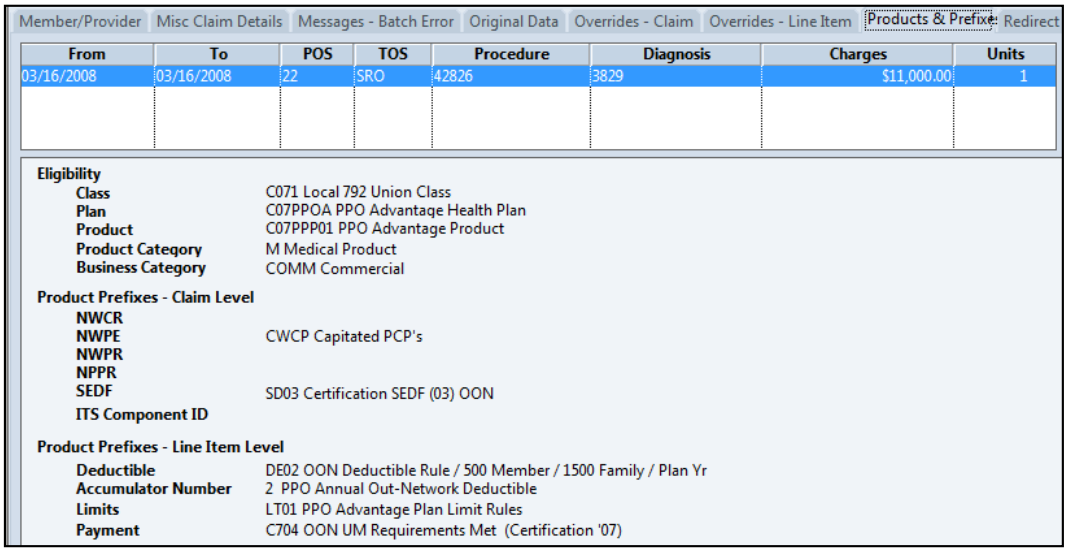
Overrides – Line Item Section Tab

In this section tab, select a line from the grid to view overrides for each line item. If no overrides exist, the text-out area will be blank.



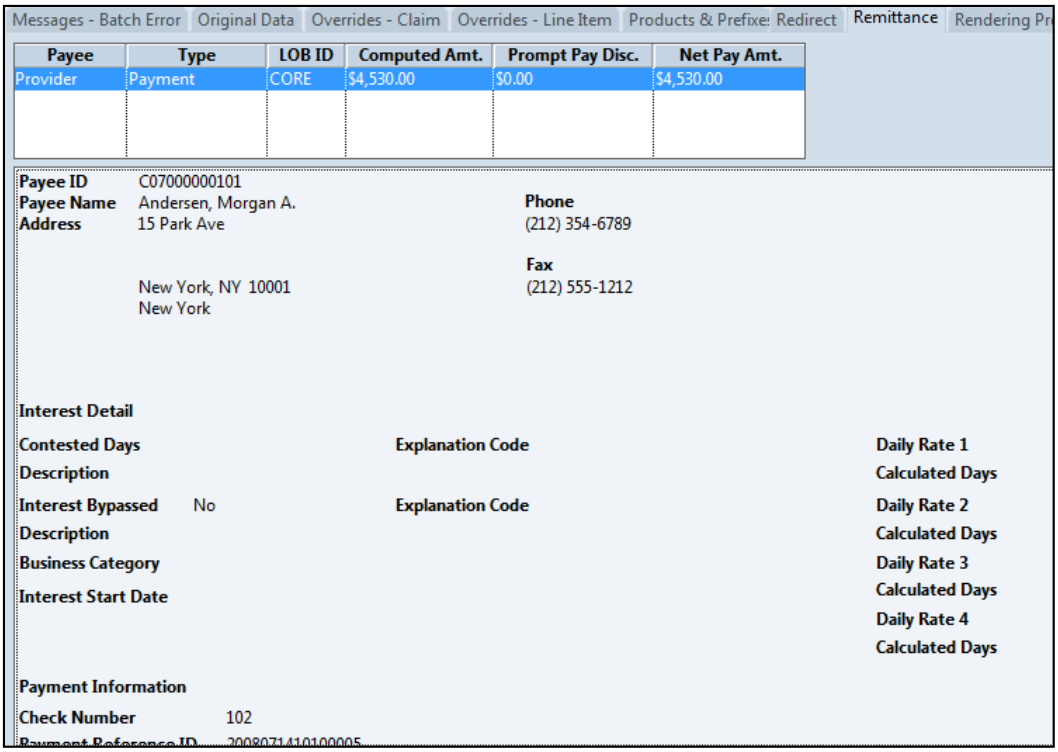
Products & Prefixes Section Tab

This section tab displays all products and prefixes associated with the selected claim.



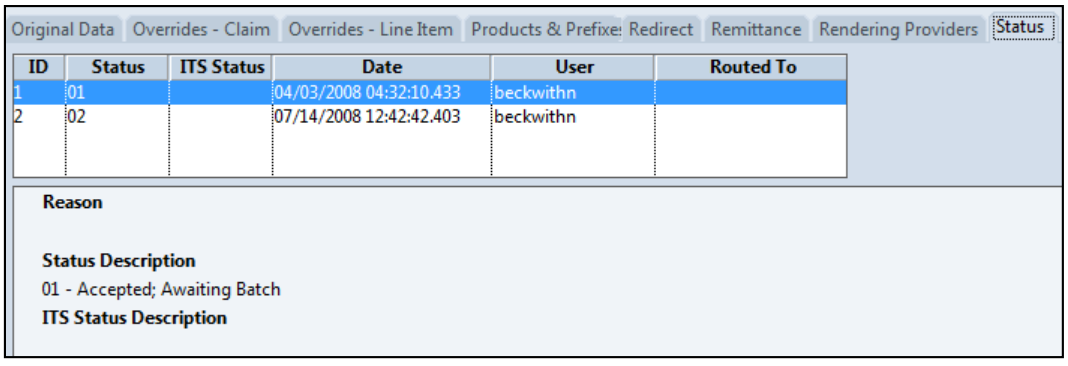
Remittance Section Tab

In this section tab, remittance information will display for the line selected.



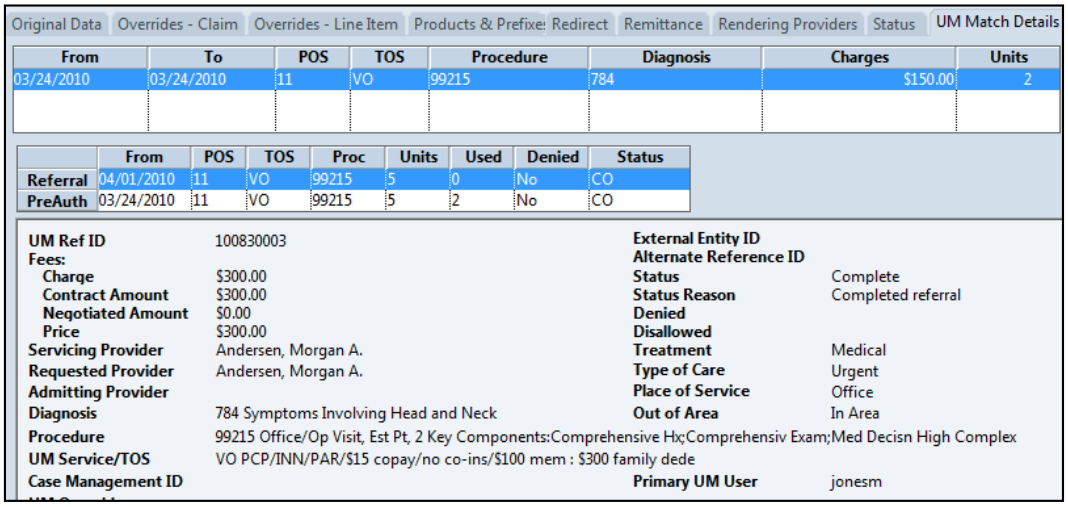
Status Section Tab

This section tab displays the status of the claim on a line-by-line item basis.



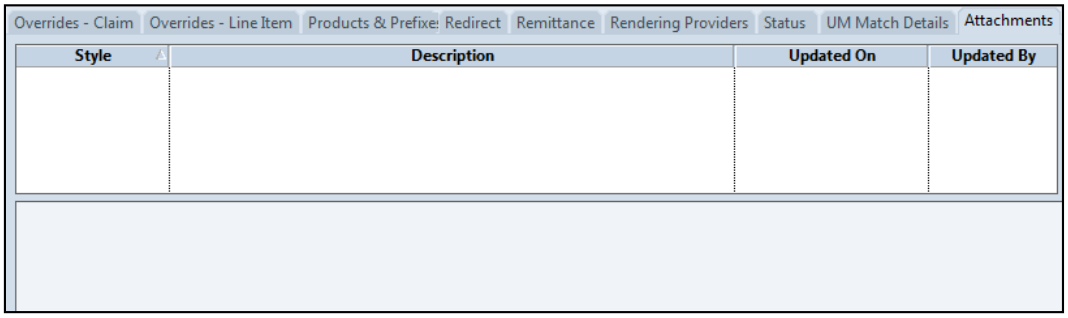
UM Match Details Section Tab

If a UM is associated with a claim, the user may view that information in this section tab. Select a line item to view the admit and discharge dates, number of authorized days, and status for referrals and pre-authorizations associated with this claim.



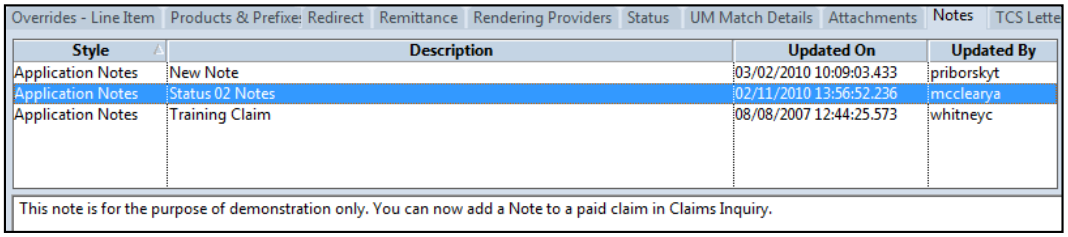
Attachments Section Tab

This section tab (scroll to the right) displays all attachments associated with the selected claim. The **Attachments** grid displays the attachment style and description. It also identifies the individual/user who last updated the attachment.



Notes Section Tab

This section tab displays any notes entered during claims processing for the selected line. To view related notes, select a line from the grid.

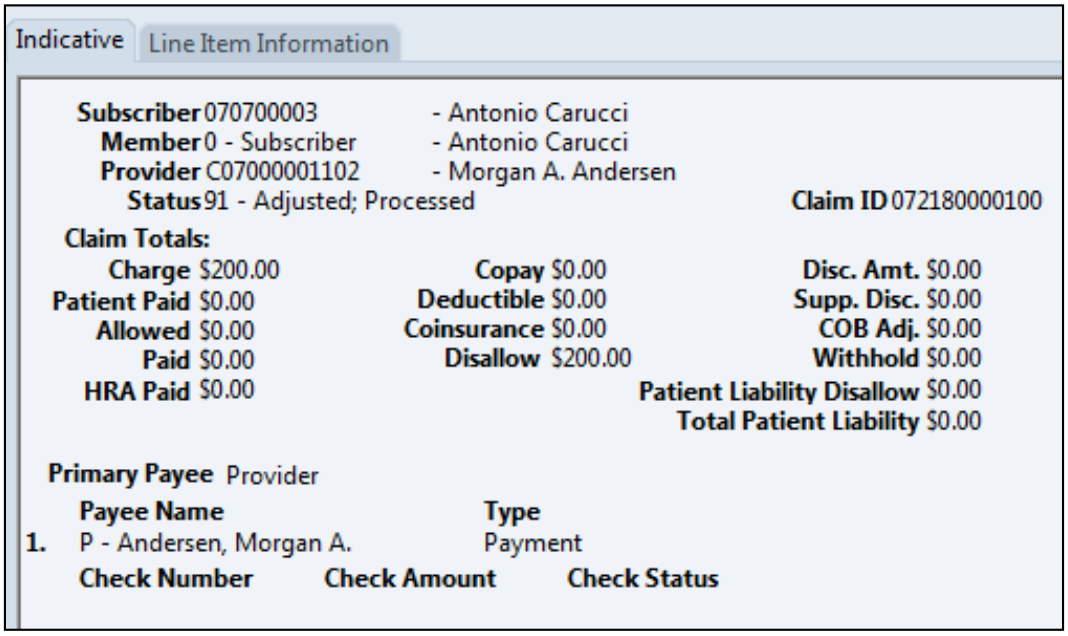


EOB/Remittance Section

This section displays a summary of claim information that might appear on the subscriber's Explanation of Benefits (EOB) or the provider's remittance.

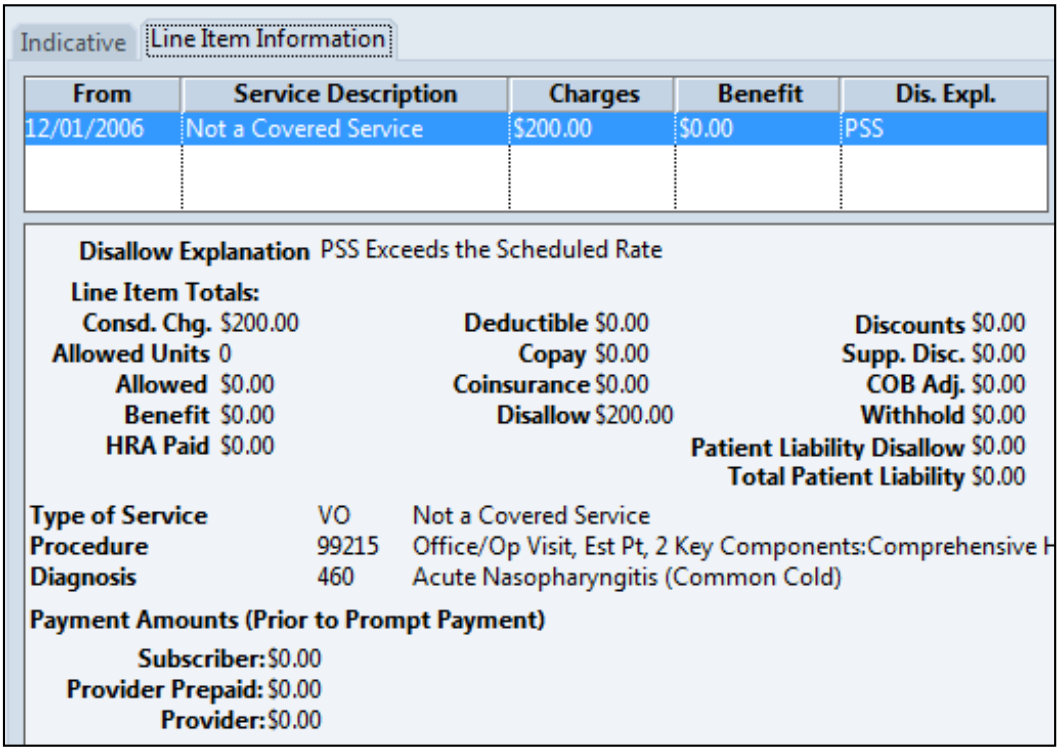
Indicative Section Tab

This section tab displays subscriber, member, provider, status, claim totals, and payee information for the selected claim. This information appears on the subscriber's EOB or provider's remittance.



Line Item Information Section Tab

This section tab displays each line item that appears on the subscriber's EOB or provider's remittance for the selected claim. The **Line Item Information** section tab grid displays the service description, charge, benefit amount, and the disallow explanation for each line item associated with the claim.

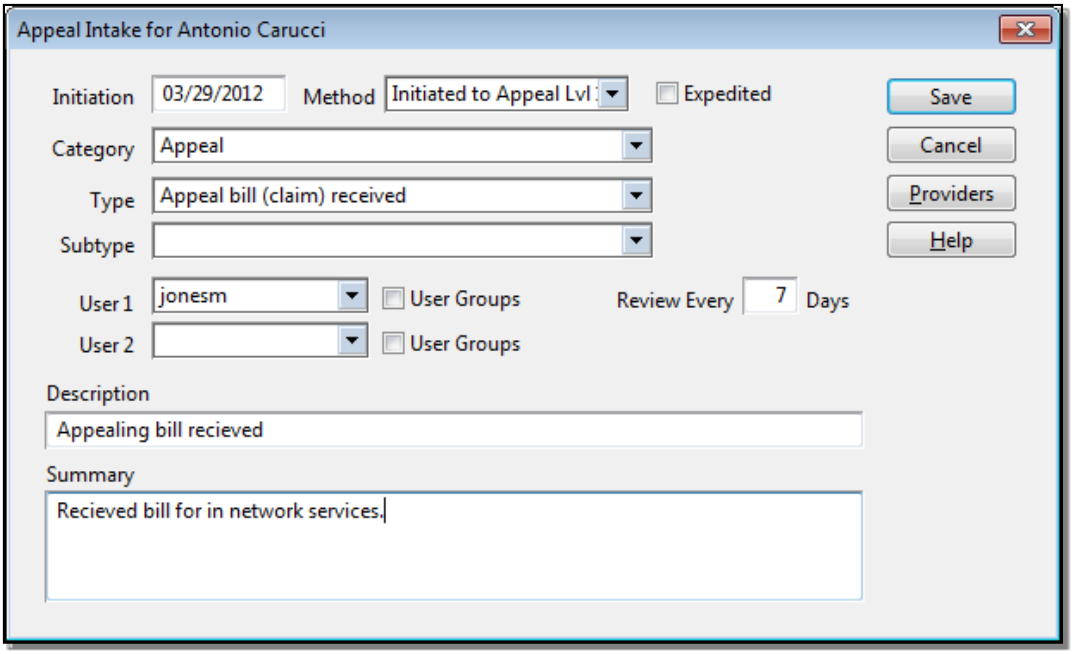


Actions Menu / Appeal Intake

This option allows a user to initiate an appeal without transferring to the Appeals application. All data entered via the Appeal Intake option is accessible in the Appeals application of the Customer Service application group; the user may transfer to this application through the **Transfer** menu.

Entering an Appeal

Step		Entering an Appeal Procedures
Steps denoted with an * are required.		
1		Select the appropriate member row in the grid.
2		Select **Alt+A+L**. **OR** Select the **Actions** menu. Select **Appeal Intake**. The **Appeal Intake** dialog box displays.
3		Complete the necessary fields.

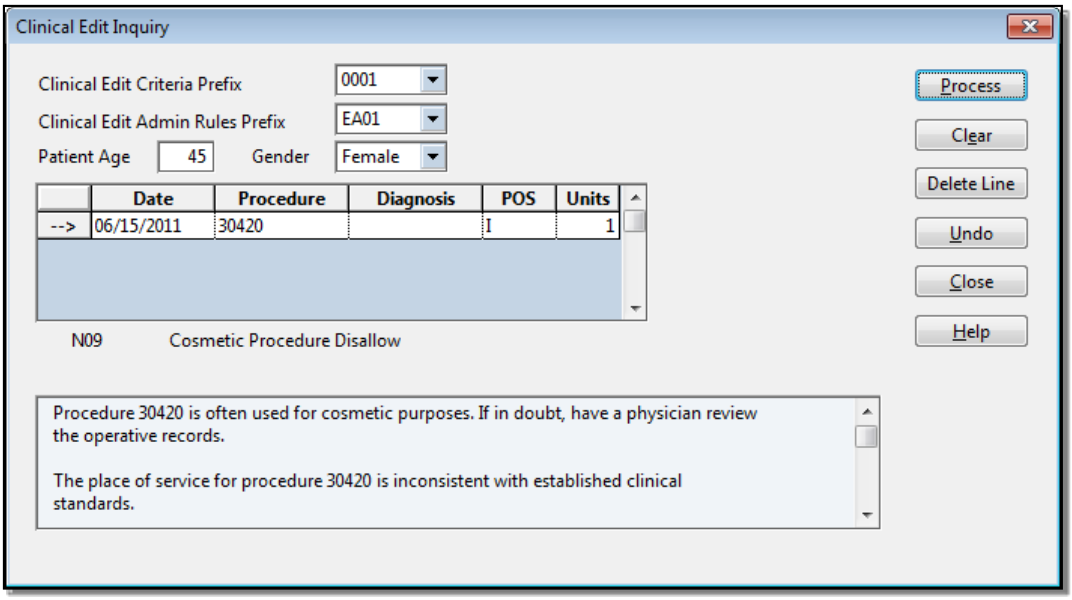


Actions Menu / Clinical Edit Inquiry

This option allows users the ability to process clinical editing results based on a service date and procedure code without having to enter a specific claim or member.

Note: The EAAR and the CECE are required on the product in order to use this **Actions** menu option.

The **Clinical Edit Inquiry** dialog box allows users to see what clinical edits would result if the selected procedure code or codes were entered for a single claim.



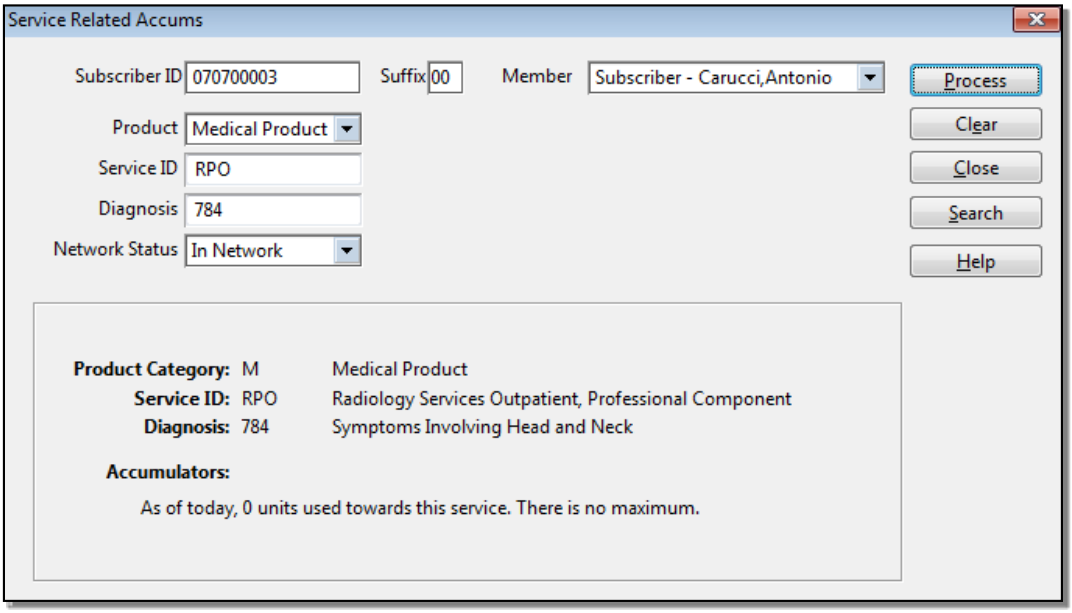
Field		Description
Fields denoted with an * are required.		
Clinical Edit Criteria Prefix	*	Select the Clinical Editing Criteria Prefix for the Product.
Clinical Edit Admin Rules Prefix	*	Select the Clinical Editing Admin Rules Prefix for the Product.
Patient Age		Enter the patient age.
Gender		Select patient gender.
Date	*	Enter the date of this clinical editing inquiry. If this field is left blank in the first row, Facets enters the current date. If it is left blank in subsequent rows, Facets enters the date in the row above it. Future dates are accepted.
Procedure	*	Enter the procedure code.
Diagnosis		Enter the diagnosis code.

Field		Description
POS		Select whether this clinical editing inquiry is for an I – Inpatient or O - Outpatient service.
Units		Enter the number of units.

Actions Menu / Svc Rel Accums

The **Service Related Accumulators** dialog box, available by selecting Svc Rel Accums from the **Actions** menu (**Alt+A+S**), displays accumulator information for a service related parameter. By entering a parameter such as the member, network indicator, or Service ID and Diagnosis, the user may view the number of units or amounts remaining in the service parameter limit.

Note: This option is available only when the query type is "Medical."



Field		Description
Fields denoted with an * are required.		
Subscriber ID	*	Enter the Subscriber ID. This field will auto-populate with the Subscriber ID for the claim selected in the **Medical** section of the Claims Inquiry application, but it may be changed. When a Subscriber ID is entered, the **Relationship/Name** field will populate with the members associated with the subscriber.

Field		Description
Suffix	*	Enter the suffix assigned to the member associated with the claim. This field will be populated with the suffix from the selected claim in the **Medical** sections grid of the Claims Inquiry application, but it may be changed. When a suffix is entered, the **Relationship/Name** field will populate with the members associated with the subscriber.
Relationship/Name	*	Select the relationship and name for the member associated with the claim. This field will be filled with the relationship/names from the selected claim, but it may be changed. When a relationship/name is entered, the **Suffix** field will be filled with the suffix associated with the subscriber.
Product Category	*	Select the Product Category.
Service ID	*	Enter the Service ID.
Diagnosis		Enter the diagnosis.
Network Status	*	Select whether the claim is “In Network,” “Out of Network” or “Participating.”

Note: The **Svc Rel Accums** button is also available in the **Medical Claims** section of the Customer Service application. Select this button to access the **Service Related Accumulators** dialog box.

Actions Menu/Add Notes

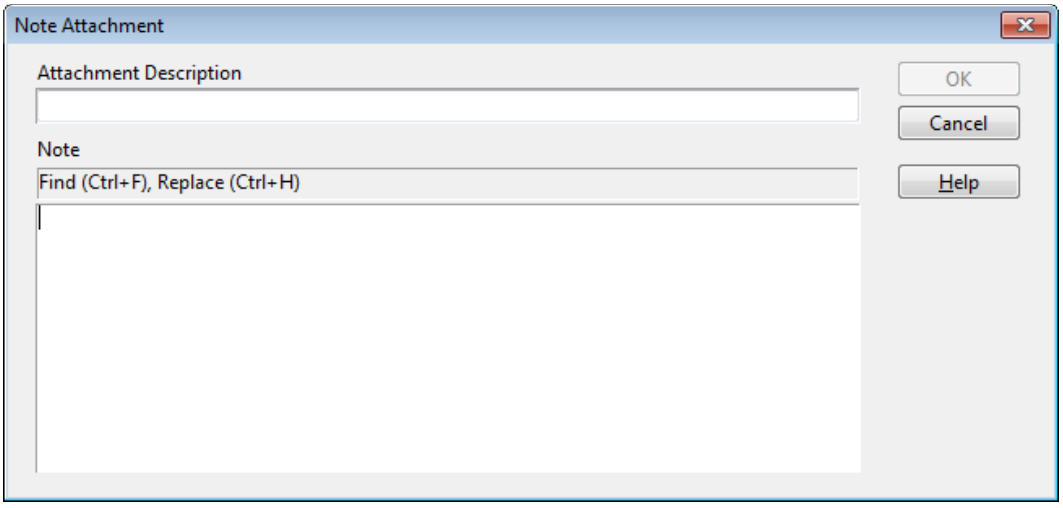
This menu option allows users to attach a note to a paid claim (status 02: Accepted; Batch Complete) without reprocessing the claim or creating an adjustment. This provides greater flexibility for health plans to track, audit, or add information to paid claims.

The **Add Notes** option through the **Actions** menu (**Alt+A+A**) is enabled only when a paid claim (status 02) is selected in the grid.

This option allows users to add notes, but notes cannot be changed or deleted without updating or adjudicating the claim.

Adding Notes

Step		Adding Notes Procedures
Steps denoted with an * are required.		
1		Select **Alt+A+A**. **OR** Select **Add Notes**. The **Notes** section tab displays. The standard **Note Attachment** dialog box displays.



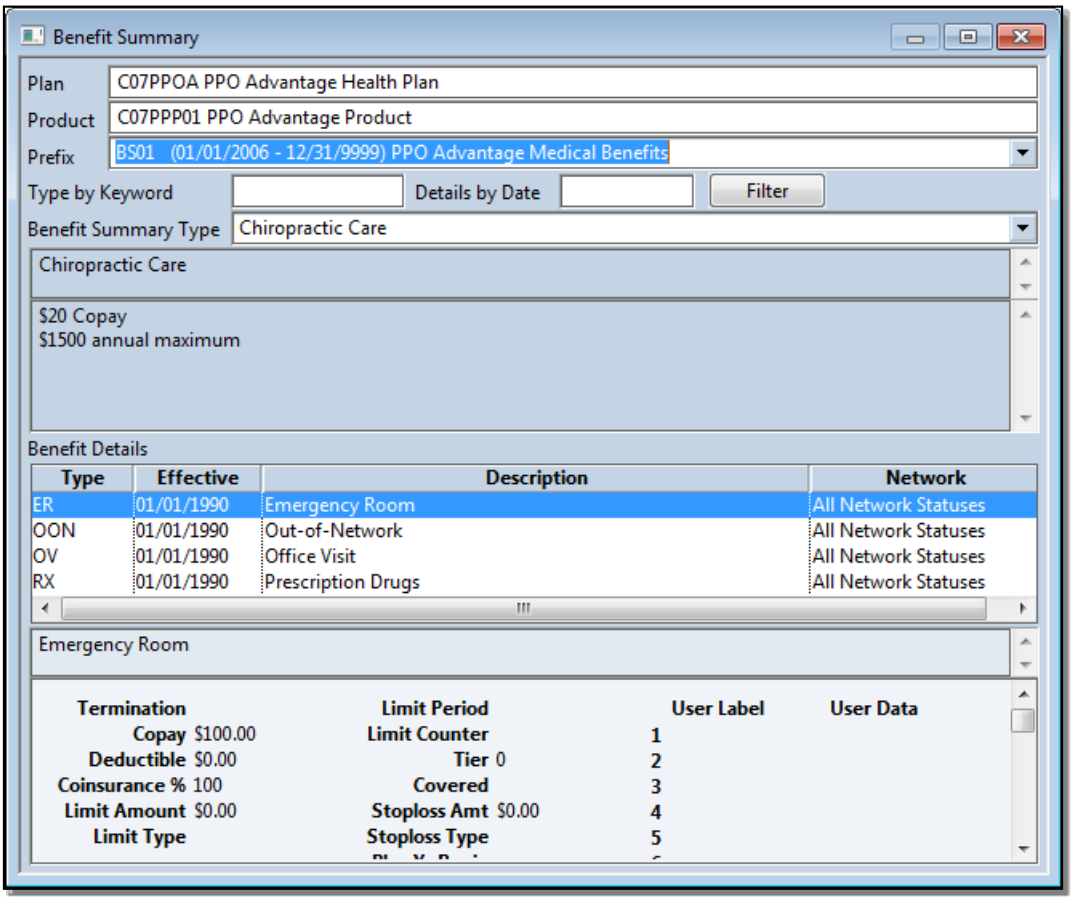
Step		Adding Notes Procedures (continued)
Steps denoted with an * are required.		
2		Complete the attachment description and note text fields.
3		Select the **OK** button.

		The **Last Action Date** on the claim updates and the note attachment saves with the claim.

View Menu

Benefit Summary (F6)

The Benefit Summary option allows a user to view information about the plan benefits for a member. This option is available only if the Benefit Summary application has been established for this plan.

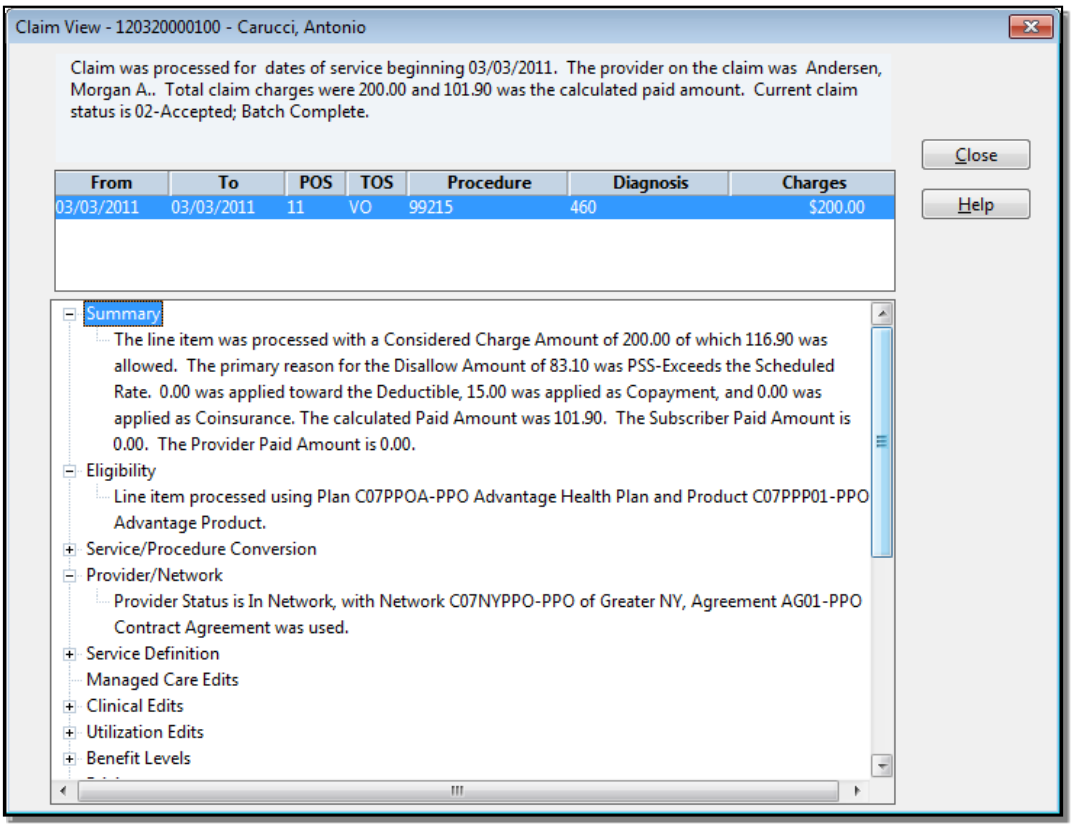


Claim View

This dialog box allows the user to quickly view the adjudication details of a selected line item for a previously processed claim. It can assist Customer Service Representatives in answering inquiries, as it presents claim adjudication information in an easy-to-read format. The data is limited to existing data saved with the claim and claim line items, and is presented in the order of the adjudication flow. The text at the top of the dialog includes the dates of service, provider, charges, and status of the claim. If applicable, CDH data is also included. The grid below the text displays the From and To dates, the Place of Service, the Type of Service, the Procedure Code, the Diagnosis Code, and the Charges for each line item on the claim.

When a line item is selected from the grid, the adjudication data for that line displays. The adjudication categories are: Summary, Eligibility, Service/Procedure Conversion, Provider Network, Service Definition, Managed Care Edits, Clinical Edits, Utilization Edits, Benefit Levels, Pricing, PCA, Medicare Supplement, Supplemental Accident Benefits, Deductibles, Limits, Service Rule, COB, Line Item Paid, Patient Liability, and CDH Account Management.

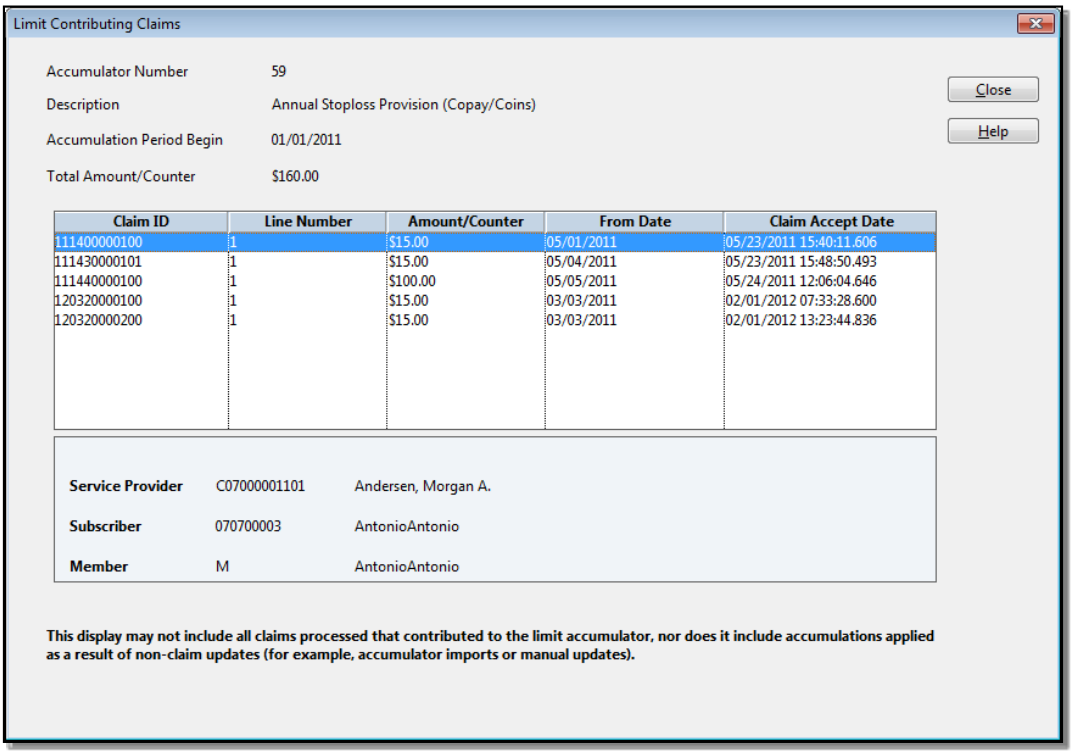
To obtain the details about an adjudication category, select the plus (+) sign next to the category. If there is no information for a particular category, that category will be unavailable and the plus or minus signs will not display.



Limit Contributing Claims (Alt+V+L):

Select this option to open the **Limit Contributing Claims** dialog box and view detailed information about claims that contribute to the accumulator limits. The dialog box displays a grid of contributing claims. Select a claim row to view additional information about these claims.

Note: This menu item and dialog box is only available when first selecting the **Accum Limits** section tab followed by an Accumulator Number row in the grid.

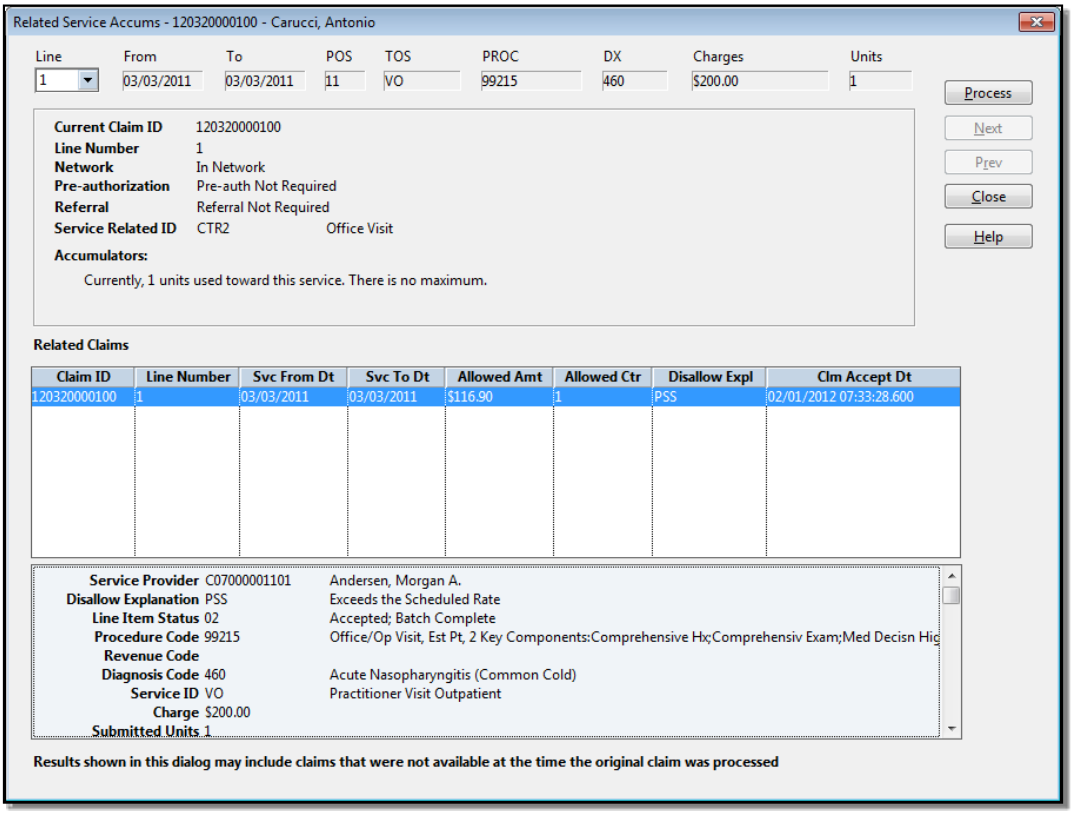


Related Service Accums (Alt+V+R)

This dialog box displays service related accumulator information. This includes units used and units remaining for a Service Related Limit for a medical claim, showing how the Service Related Parameter was derived.

This menu item will only be available when user security permits, when a line item for a claim in status 01, 02, or 11 has been selected, and only for inquiries performed on medical claims. In all other instances, the menu item will be grayed out and unavailable for selection.

This dialog box displays only; however, users may select various claim lines in the **Line** field.



The **title bar** on the dialog box displays the currently selected Claim ID and the member's first and last name.

The **Current Claim** section displays the data used to identify the Variable Component row used to adjudicate the currently selected Line item. The **Network**, **Pre-authorization,** and **Referral** fields contain data obtained directly from the **Claim Line Item** (CDML) table.

The **Related Claims grid** displays the claims that contributed toward the calculation performed in the **Current Claim** display area (inclusive of all lines from the current

claim, including the current line item, if applicable). This section will only include claims with status 01, 02, or 81.

Note:

The results of the query may differ from the results that occurred at the time the claim was processed due to additional claims that may have been processed in between the time the claim was originally processed and the time of the Claims Inquiry query

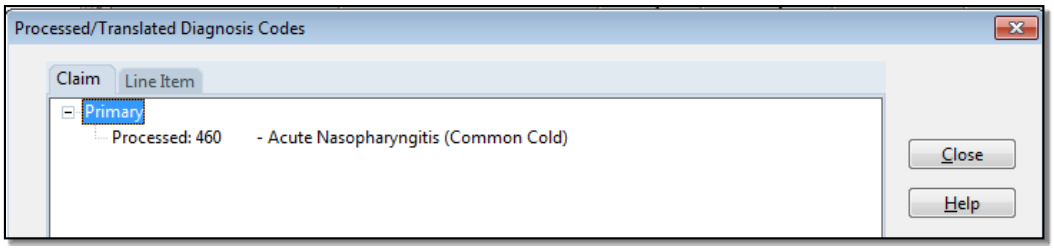
Service tiers will not be read, so the display will not include daily co-pay logic

Customer Service users may access the new dialog box by transferring to Claims Inquiry

Processed/Translated Codes / Diagnosis or Procedure (Alt+V+P+D/P)

Select this option (**Alt+V+P+D**) to open the **Processed/Translated Diagnosis Codes** dialog box and review the Diagnosis Set and diagnosis codes at the claim and line item level. This menu option is available only when a claim has been processed.

The **Claim** tab displays the claim-level diagnosis codes and the **Line Item** tab displays the line item-level diagnosis codes. Select the "+" sign to view the Processed and Translated codes and their corresponding descriptions.

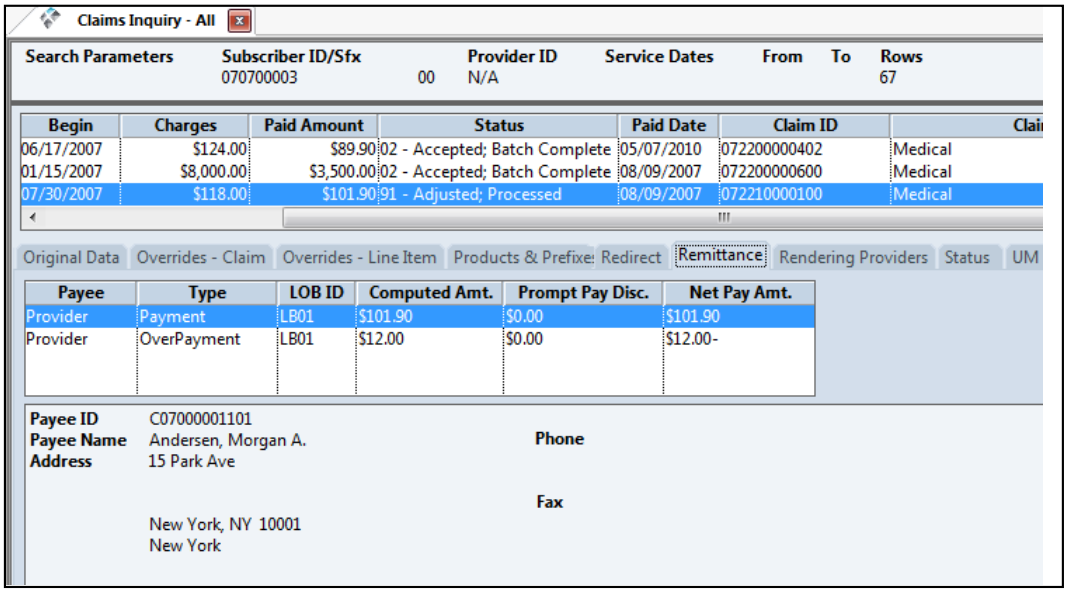


Note: Select **Alt+V+P+P** to open the **Processed/Translated Procedure Codes** dialog box and review Procedure Codes for the claim.

Overpayment Recovery Set-up and Process

Starting from the Claims Inquiry application, the following screen prints are in the order of a claim that was adjusted for reasons of an overpayment to a provider. More detailed information is given for applications that have not yet been shown in this section that are related to the Overpayment Recovery process, e.g. Payment Reductions application.

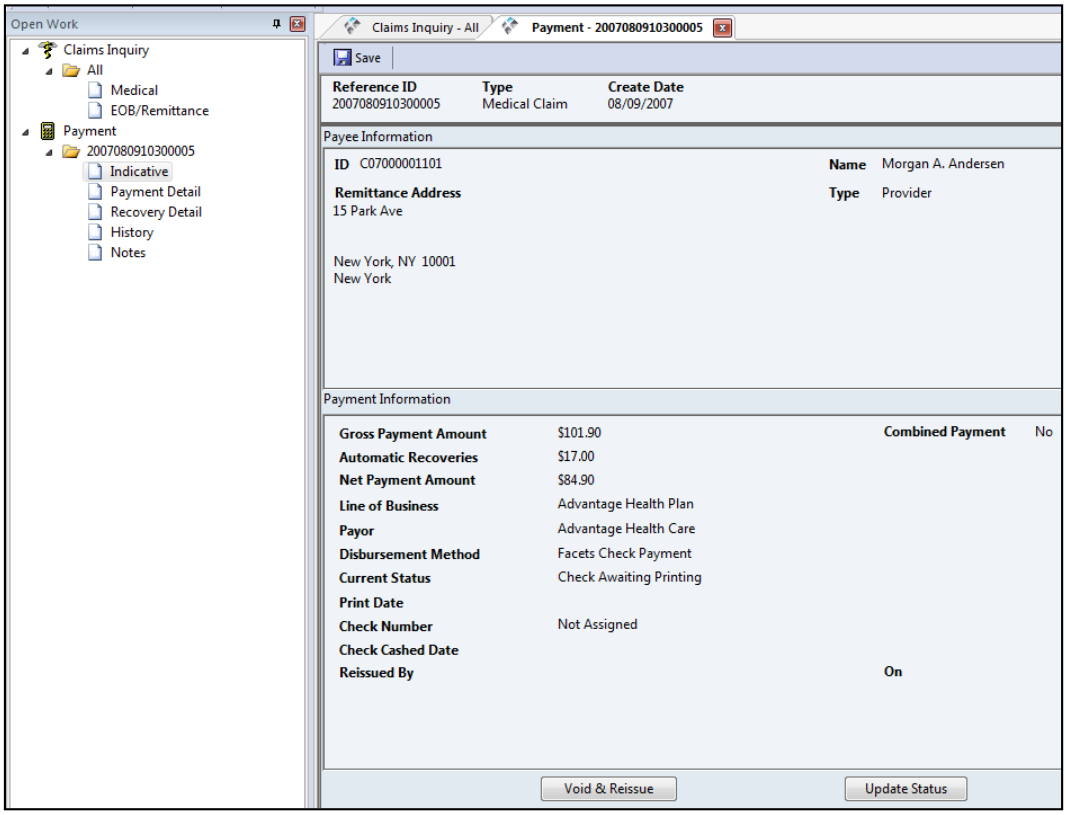
Claims Inquiry Application



Claim #072210000100 is now in a 91 status (Adjusted; Processed) after being adjusted for an overpayment. Originally a payment of $101.90 was processed and sent to the provider, Dr. Morgan A. Andersen. After the payment was processed, the claim was adjusted to show a payment of $89.90, which resulted in an overpayment of $12.00 to Dr. Andersen. When this adjustment was done, Facets recognized that the LOB ID associated with the payment was 'LB01.'

The LB01 Line of Business file (and the **Payment** section of Dr. Morgan practitioner's file) indicates that Facets should automatically recover money from future payments to a payee to satisfy any outstanding balances recognized as overpayments in the Payment Reductions application found in the Accounting application group. In the case of Dr. Morgan, after the 072210000100 claim was adjusted and processed for payment (status 02), an Overpayment Balance row of $12.00 was added into the Payment Reductions application for him.

Payment Application



Indicative Section

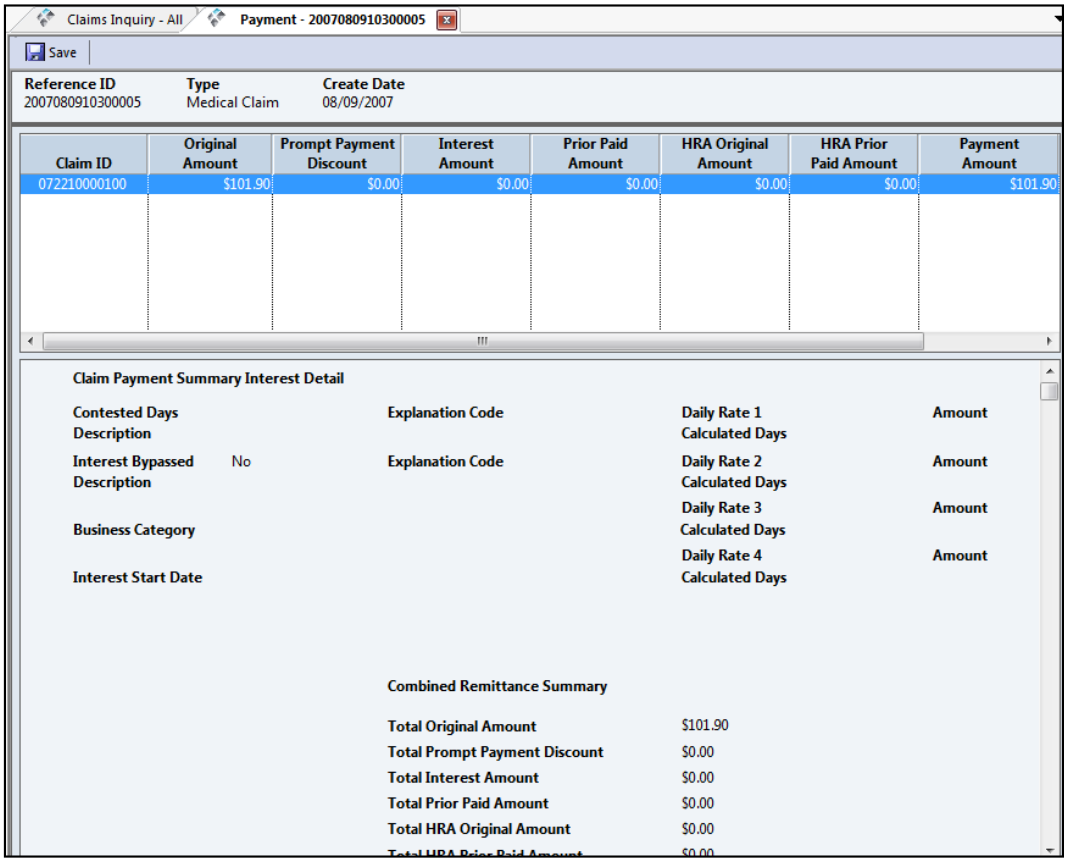
This section identifies the payee and the remit address for the payee. In the Payment Information portion of the section Facets will indicate if the Gross Payment Amount ($101.90) is subject to an automatic payment reduction by displaying an amount in the **Automatic Recoveries** field. This payment was subject to a recovery of $17.00. Only one claim paid amount is related to the Payment Reference ID as indicated by the status of "No" in the **Combined Payment** field. Also, notice that the Line of Business associated with this payment is, Advantage Health Plan (LOB ID: LB01).

The **Indicative** section of the Payment application also offers the functions of Void & Reissue of a check, and the ability to update the status of a check.

Button	Description
Void & Reissue button	After selecting the **Void & Reissue** button, the **Void & Reissue** pop-up box displays.
Update Status button	After selecting the **Update Status** button, the **Update Status** dialog box displays.

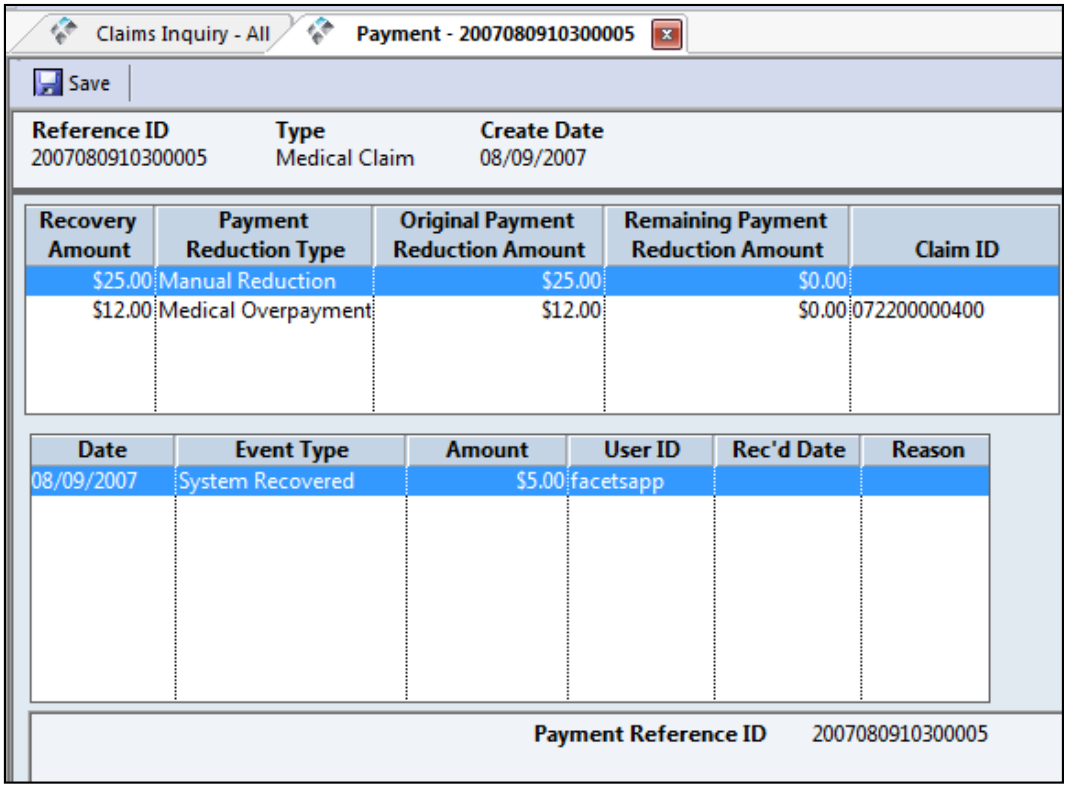
Payment Detail Section

This section lists all claims related to the Payment Reference ID shown in the **Record Information** area of this section. It indicates the Claim ID, the Original Payment Amount, Prompt Payment Discount amount, any Interest that was applied to the claim payment, and if the payee had been initially under-paid, in which case the Prior Paid Amount will also display. These amounts are taken into account when calculating the Gross Payment Amount. HRA (Health Reimbursement Arrangements), Original Amount, and Prior Paid Amount are only updated if HRA CDH (Consumer Directed Healthcare) benefits are incorporated in the medical benefits. The SCCF (Standard Claim Collection Filing) Serial Number is related to ITS (Inter-Plan Teleprocessing Services) claim processing functions. The "Combined Remittance Summary" title separates remittance level details from claim payment summary levels displayed under the "Claim Payment Summary Interest Detail" title found in the text-out area below the grid.



The Recovery Detail Section

This section of the Payment application will list in the top grid all recovery (overpayment balance) rows that were repaid fully or partially from the payment amount that is related to the Payment Reference ID shown in the **Record Information** area of the Workspace.



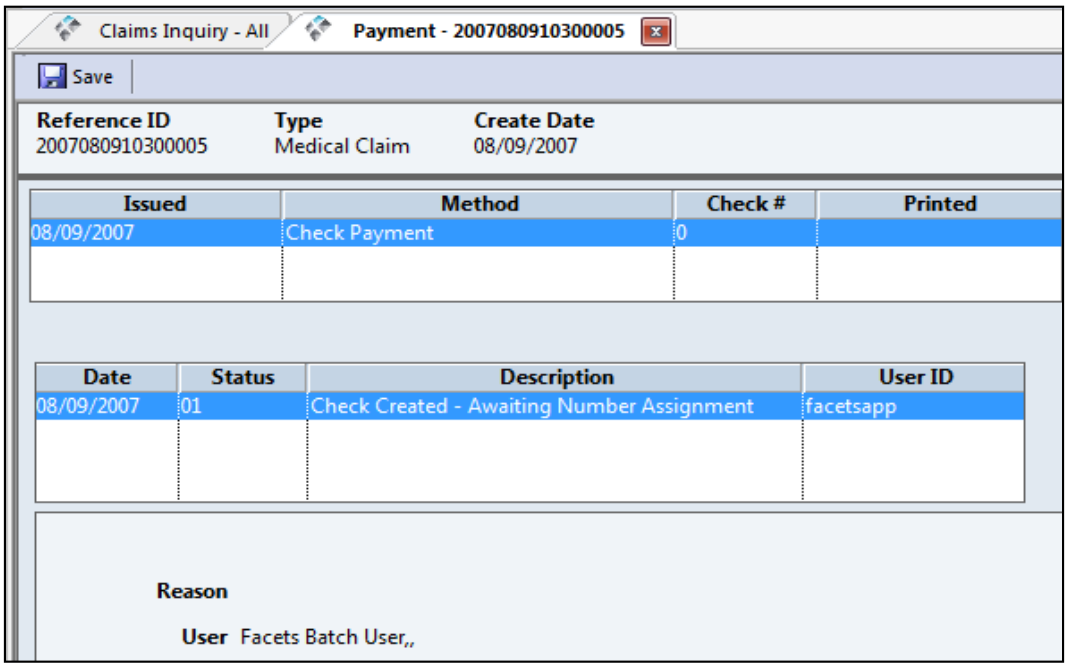
Field		Description
Fields denoted with an * are required.		
Recovery Amount		The amount of the overpayment balance that needs to be recovered.
Payment Reduction Type		The type of overpayment balance row to which the recovery amount was applied.
Original Payment Reduction Amount		The original overpayment balance amount.
Remaining Payment Reduction Amount		The remaining overpayment balance after money has been recouped from the current payment.
Claim ID		The claim ID that was adjusted that resulted in the creation of an Overpayment Balance row.

For each row that is displayed and selected in the top grid of the **Recovery Detail** section, a related row will display in the second grid identifying specific information about funds recouped from a payment used to reduce an overpayment balance.

Field		Description
Fields denoted with an * are required.		
Date		Date the recovery amount was applied.
Event Type		How the recovery was made: i.e. System Recovered (automatically).
Amount		The amount of the payment that was applied to the Overpayment Balance row.
User ID		ID of the user associated with the recovery (i.e. a Batch ID).
Rec'd Date		If a Receipt or Write-Off is entered a Receive Date of the entry must be entered. Updated via the Payment Reductions application.
Reason		The reason why a Receipt or Write-Off was entered. Updated via the Payment Reductions application.

History Section

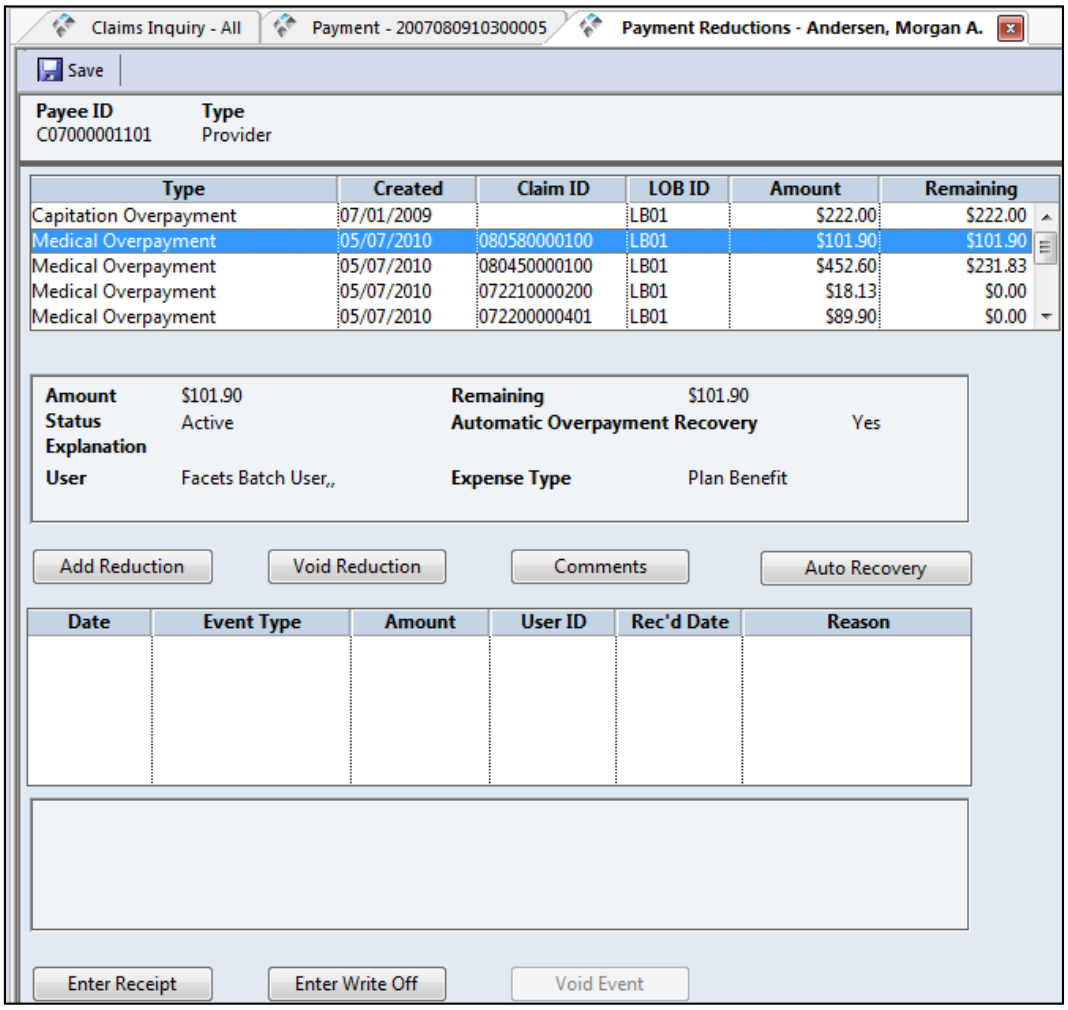
In the second grid of this section of the Payment application, Facets will list the various statuses that a payment has gone through as it relates to a specific (selected) Issued date in the top grid. A Payment can list multiple Issued dates if a payment has been Voided and Reissued.



Notes Section

This section can be used to manually enter notes concerning the Payment.

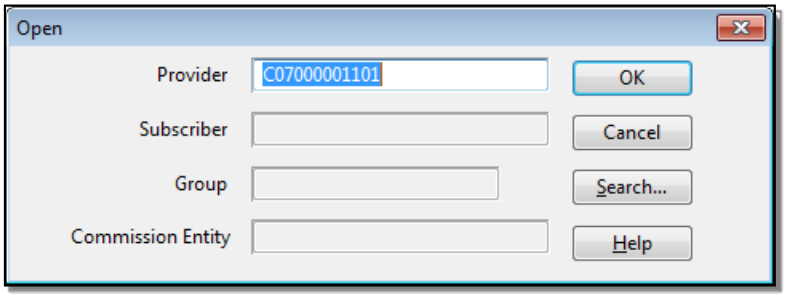
Payment Reductions Application



Focusing only on the second row of information in the top grid of the above application, note that this Overpayment Balance row was created after two steps. First an adjustment had to be made to a claim, and second, the claim had to go through the Payment Batch cycle. Only after the Payment Batch cycle has been completed can a user be able to see an Overpayment Balance row in the Payment Reductions application for a provider.

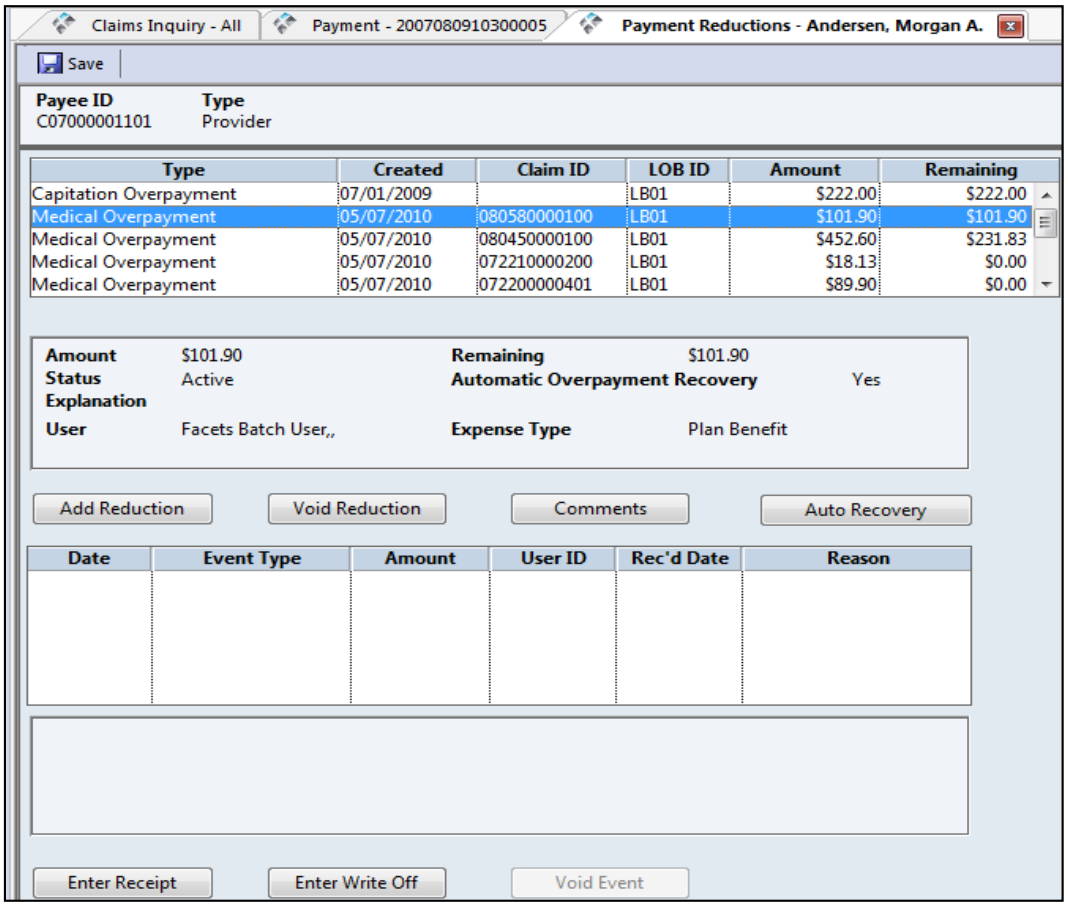
If a payee has no existing Overpayment Balance rows and one is being created manually, the following dialog box would have to be completed for the payee by selecting **New** from the **File** menu (**Ctrl+N**). For payees who have Overpayment

Recovery history, select Open from the **File** menu (**Ctrl+O**) and enter the ID of the related payee.



Initially an Overpayment Balance row will indicate matching totals under the **Amount** and **Remaining** columns. The **Amount** column indicates the amount of the overpayment, while **Remaining** column indicates the amount of the overpayment that has not yet been recovered.

The Payment Reductions application will display all of the Overpayment Balance rows for a payee (Provider, Subscriber, Group, and Commission Entity), identify how the row was created, and any recovery history associated with each the row. The list of rows is sorted by LOB ID in descending date order categorized by the **Type** field.



The Overpayment Balance rows listed in the top grid of the Payment Reduction application displays the following information: the Type of overpayment (automatic or manual), the date the overpayment was created, the adjusted Claim ID that triggered the creation of the Overpayment Balance row, the LOB ID, the overpayment Amount, and the Remaining overpayment balance.

The Status of "Inactive" is displayed when there is no remaining balance; otherwise the status will be "Active." The Explanation of Benefits (EOB) displays only for manual reductions. The User and Expense Type data is automatically updated by the system. For manually entered Overpayment Balance rows a user-defined Expense Type can be selected. The **Automatic Overpayment Recovery** field is activated by a claim override. Use the **Add Reduction** button to manually add an Overpayment Balance row. The **Void Reduction** button offers the ability to void manually entered Overpayment Balance rows before they are saved within the Payment Reductions application. Comments can be entered for any Overpayment Recovery row. The **Auto Recovery** button offers the ability to change the entry in the **Automatic Overpayment Recovery** field for any listed Active Overpayment Balance row.

The second grid in the Payment Reductions application displays details about the payment recovery specific to each Overpayment Balance row once it is selected in the top grid of the application.

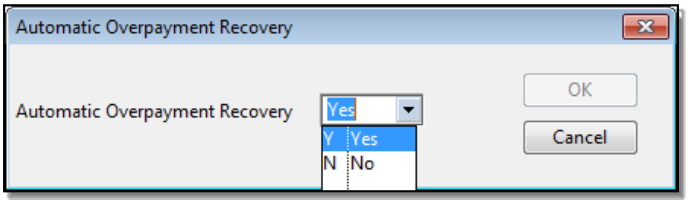
Field		Description
Fields denoted with an * are required.		
Date		When money was recovered or entered to reduce the overpayment.
Event Type		Indicates how the recovery was made.
Amount		Indicates the amount that was recovered or entered to reduce the overpayment balance.
User ID		The User ID associated with the recovery.
Received Date		The actual date the funds were received.
Reason		User-defined reason for the Receipt or Write-Off.

The screen print on the previous page shows that a recovery of $12.00 was made on 08/09/07 and it was taken from a payment related to Payment Reference ID: 2007080910300005.

Bypass Overpayment Recovery (Recouping the Payment)

Facets will automatically create a payment reduction row for a provider once the claim has been adjusted in the Payment Reduction application. There are four places you can bypass overpayment recovery, because based on rules you may have to send letters prior to recouping the funds. We will now look at the places you can bypass overpayment recovery:

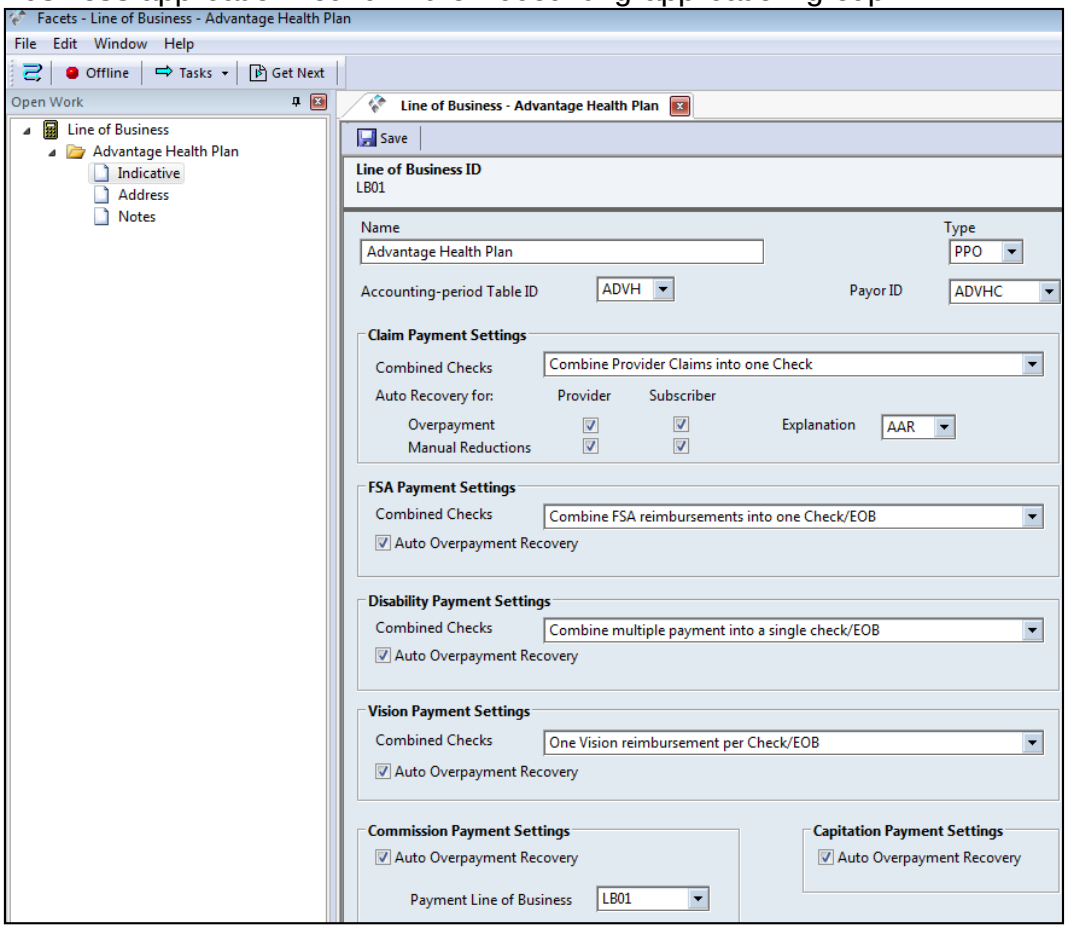
Payment Reduction Application (Auto Recovery Button)

Button	Description
Auto Recovery button	After selecting the **Auto Recovery** button, the **Automatic Overpayment Recovery** dialog box displays. 

Note: Security can be attached to the **Auto Recovery** button. Facets will verify the user's permissions to determine whether or not the user can select this button and apply auto payment recoveries. If the user has permission to apply auto payment recoveries, the **Auto Recovery** button will be enabled and available to the user. If the user does not have permission to apply auto payment recoveries, this button will be grayed-out and not available to the user.

Line of Business Application

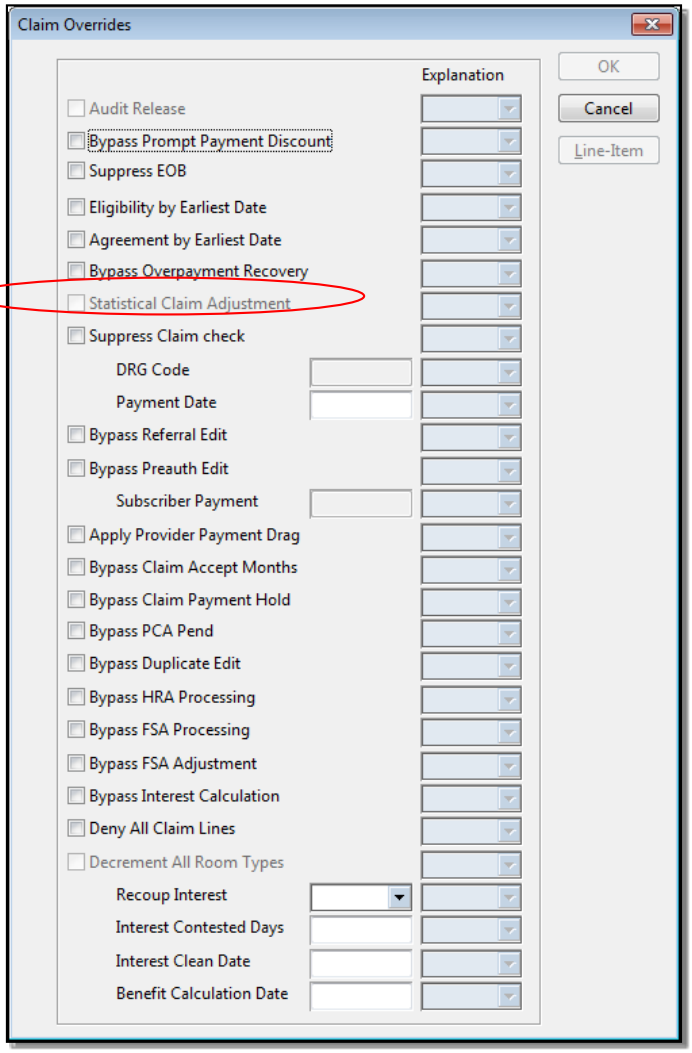
A Line of Business ID and the information that is related to it is created in the Line of Business application found in the Accounting application group.



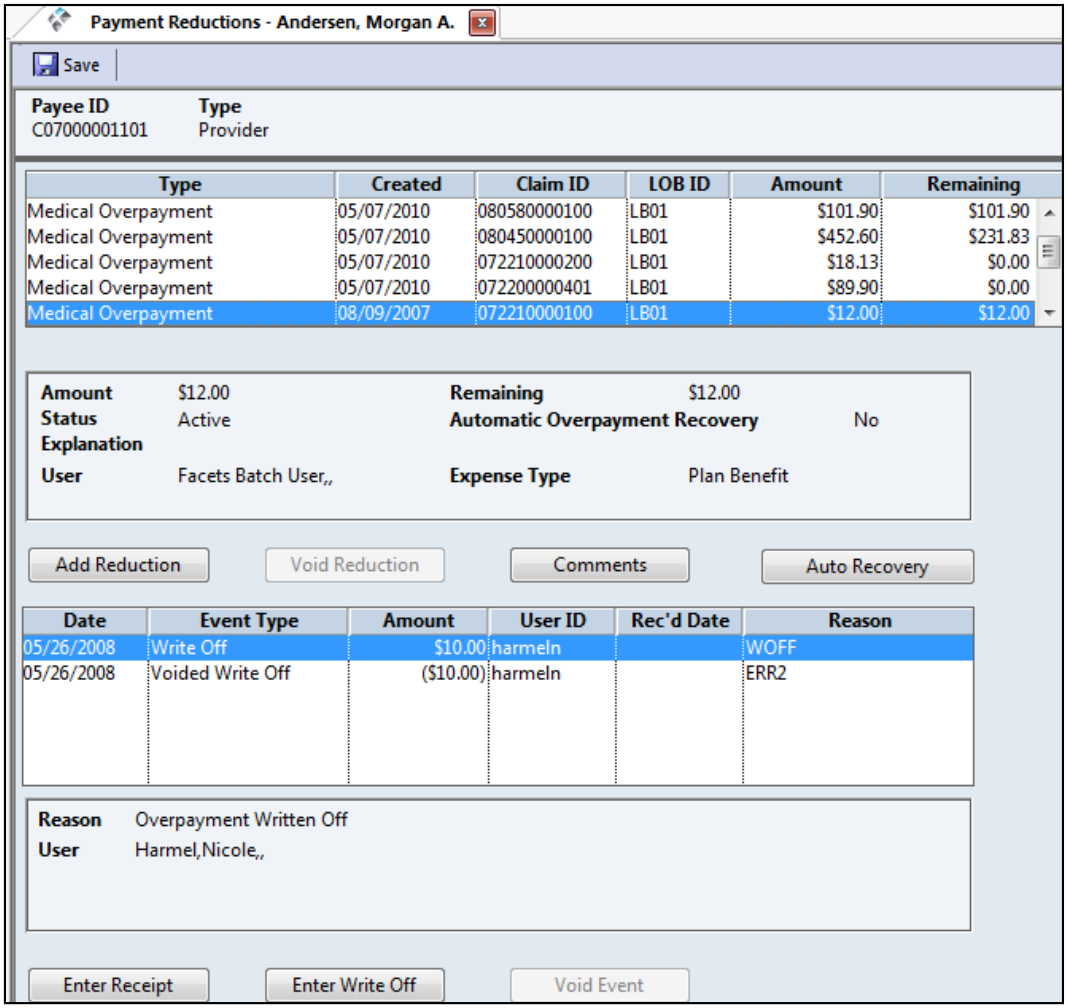
The Line of Business application provides a means of tracking revenue that is disbursed by a given Product. The application includes a **Name** field, an **Address** section (optional), and a user-defined Type. The payer (who signs the check for the payment) associated with the Line of Business, and an Accounting Period ID is also identified.

The Line of Business application also determines how overpayments are recovered from subsequent claim, capitation, and commission payments.

Claims Processing Application (Claims Level Override)

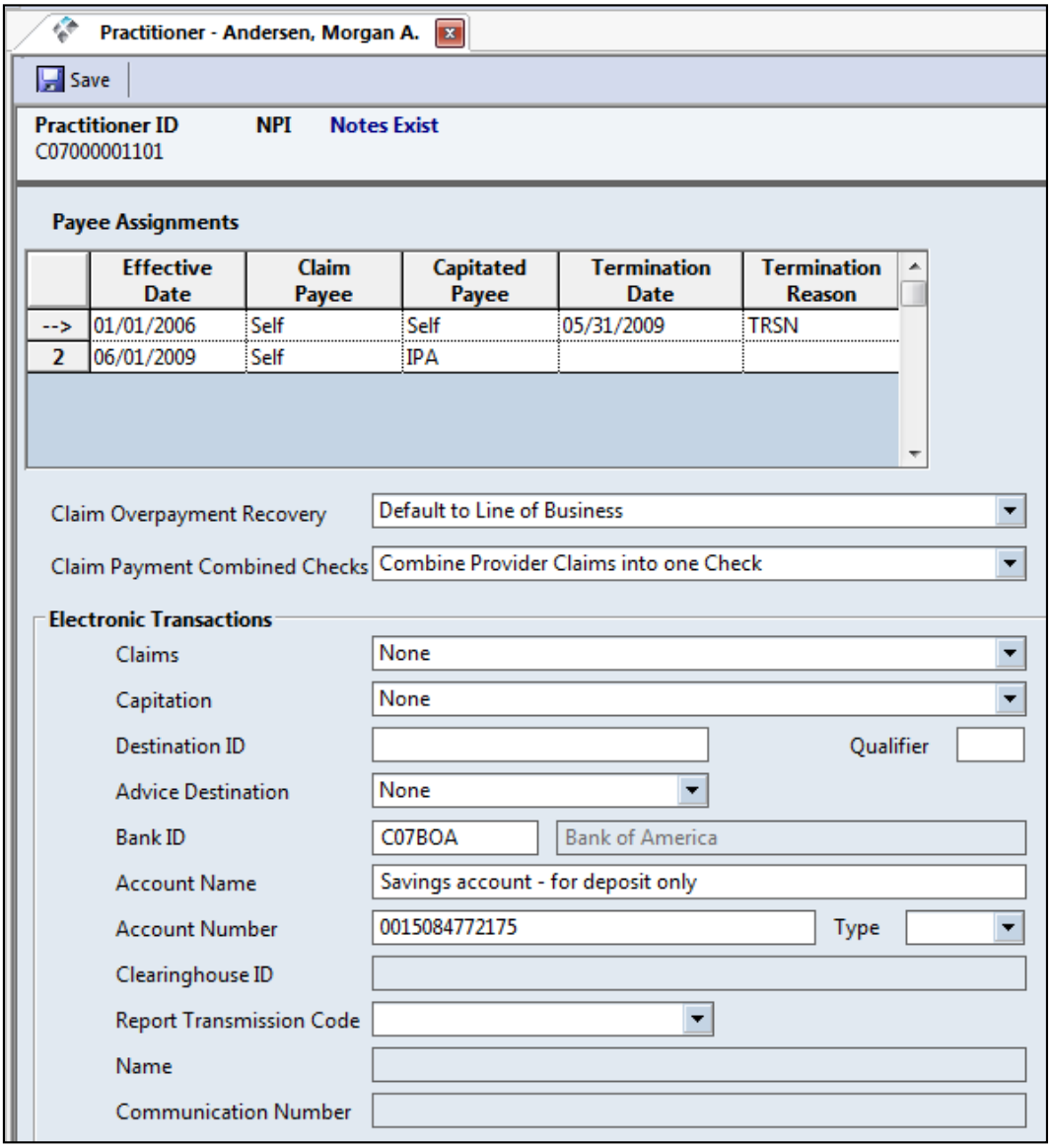


When selecting the “Bypass Overpayment Recovery” override in the Claims Processing application when making the adjustment, Facets is instructed not to recover money from future claims that resulted in a paid benefit for the payee.



As a result of the override, the Remaining amount in the Overpayment Balance row selected in the screen print above can only be recovered via the entry of a Receipt or a Write Off.

Provider Application (Payment Info Section)



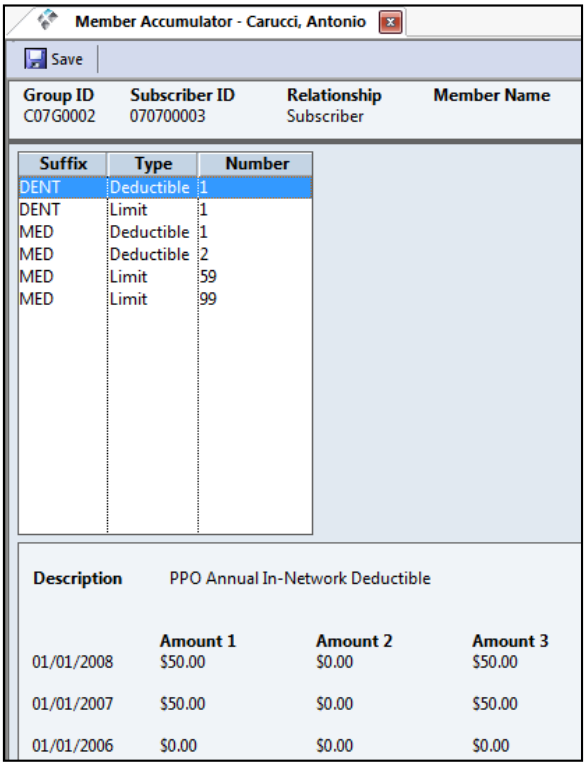
Note: A **Claim Overpayment Recovery** field is also available on a provider's file (Practitioner, Facility, Provider Group, IPA), and the selection made in this field with supersede the selection that is made in the Line of Business application.

Member Accumulator Application

The information stored in the Member Accumulator application is updated automatically based on claims processing, claims adjustments, or entered manually right in this application. Data displayed here is member specific. Use this record to view the accumulation of Deductible and COB dollars, Limit amounts, counters, and Dental Incentive Coinsurance.

Accumulators Section

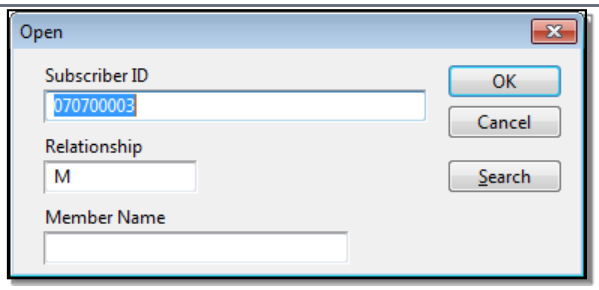
Health care benefits may be provided to eligible members with restrictions or limits placed on certain items. These restrictions or limits are each linked to an accumulator bucket that allows the limits and restrictions to be tracked for a specific amount of time.



Field		Description
Fields denoted with an * are required.		
Suffix	*	Indicates the Accumulator Suffix ID that was found on the product.
Type	*	Indicates the type of accumulator; i.e. COB, Deductible or Limit.
Number	*	Indicates the Accumulator Number.

Accessing the Member Accumulator (security dependent)

Step		Accessing Member Accumulator Procedures
Steps denoted with an * are required.		
1		Select **Ctrl+O**. **OR** Select the **File** menu. Select **Open**. The **Open** dialog box displays.

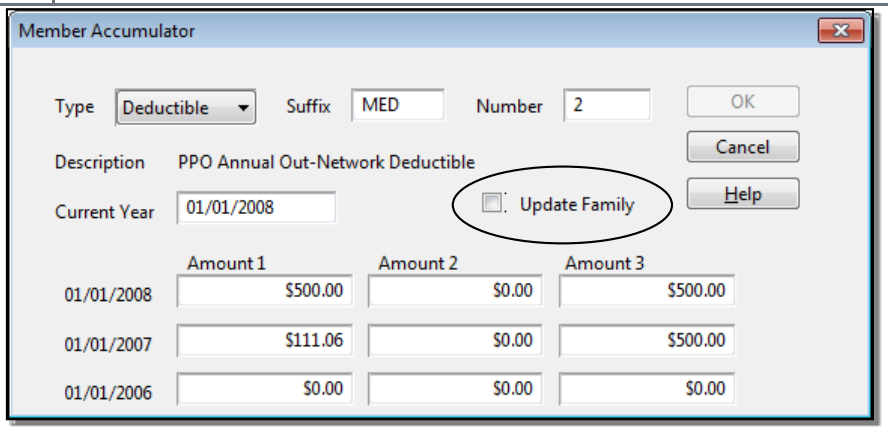


Step		Accessing Member Accumulator Procedures
Steps denoted with an * are required.		
2		Enter the subscriber ID in the **Subscriber ID** field.
3		Enter the relationship in the **Relationship** field. **Note:** The **Relationship** field accepts a two-character member relationship code value. Available relationship codes are: • M = Subscriber • H = Husband • W = Wife • D = Daughter • S = Son • O - Other **Note:** If M is used the member name does not need to be entered.
4		Enter the member name in the **Member Name** field.
5		Select the **OK** button. The **Accumulators** section displays.

In the **Accumulators** section, select a line in the grid to view accumulator information in the text-out area below. The text-out area displays the actual dollar amounts accumulated for the current year and the two previous years for that accumulator type (Deductible, COB, Limit, or Dental Incentive Coinsurance).

Adding Member Accumulators

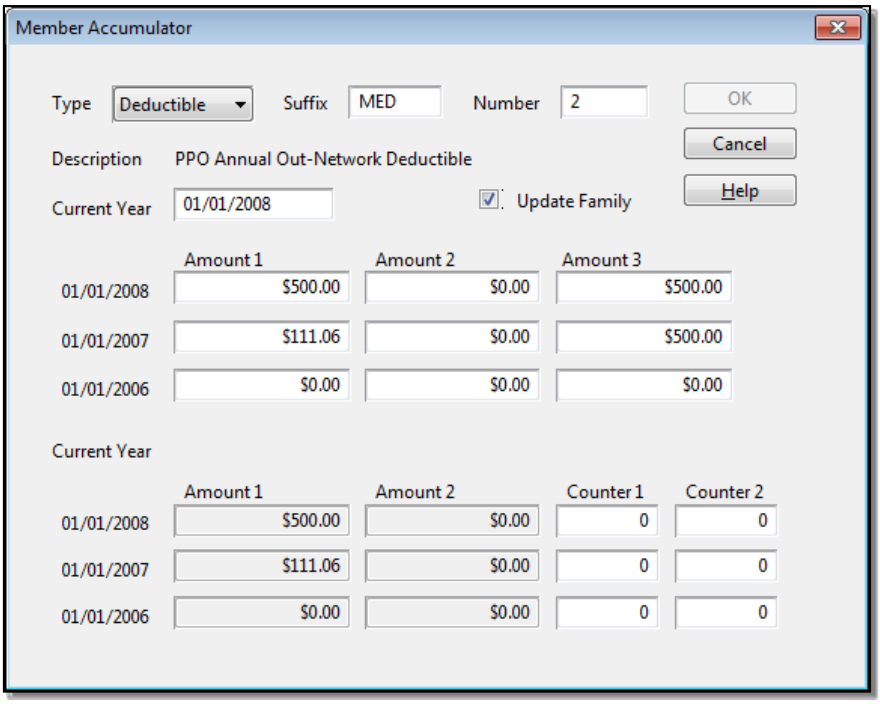
Step		Adding Member Accumulators Procedures
Steps denoted with an * are required.		
1		Select **Alt+E+A**. **OR** Select the **Edit** menu. Select **Add**. The **Member Accumulator** dialog box displays.



The user may make the appropriate changes/additions and may also select to automatically update the Family Accumulator record for that member [with Limit and Deductible amounts]. This is done only if there is a matching Family Accumulator bucket number (Facets will edit to verify that the accumulator being updated is also a valid family accumulator).

If there is a matching/valid bucket number, the user may select the **Update Family** checkbox; this will be disabled if there is no member-to-family accumulator match. This option allows the user to update the family accumulators at the same time that the member's accumulators are being updated.

Updating Member and Family Accumulators



When the **Update Family** checkbox is selected and a matching Family Accumulator exists, Facets will respond with an expanded **Member Accumulator** dialog box.

Step		Updating Member and Family Accumulators Procedures
Steps denoted with an * are required.		
1		Enter the appropriate amounts in the applicable fields. Facets calculates the difference between the original amount and the new amount entered, and then performs the calculation. The difference is applied to the member's appropriate Family Accumulator record.
2		Select the **File** menu and select **Save (Ctrl+S)**.

Keep in Mind…

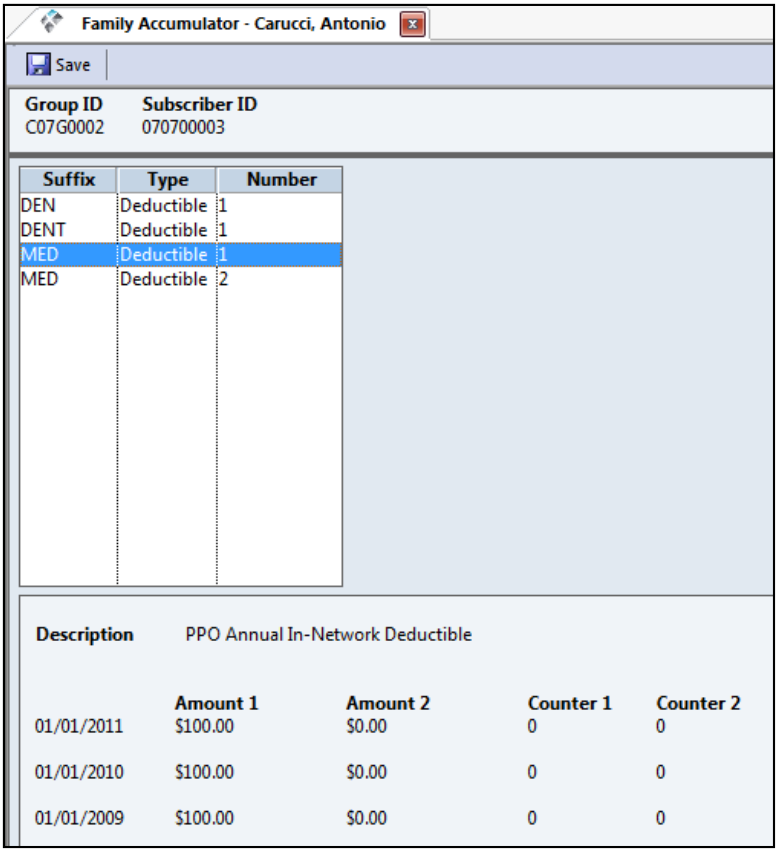
- The **Amount** fields in the **Family Accumulator** area are unavailable because Facets automatically does this calculation when amounts are entered in the **Member Accumulator** fields. However, the user may manually update the **Family Counter** fields.
- To correct the family accumulator amounts, they must be corrected in the Family Accumulator application.
- Claims will automatically continue to update the appropriate Member and Family Accumulator records; this expanded dialog box is used for manual updates, as necessary, with the appropriate level of security.

Family Accumulator Application

The information displayed in the Family Accumulator application is similar to the Member Accumulator application. The difference is that the accumulators listed in the grid of this application apply to the entire family.

Accumulators Section

This section displays the type and total of each amount being accumulated by a particular family. This section also specifies the period of time over which these amounts were accumulated.

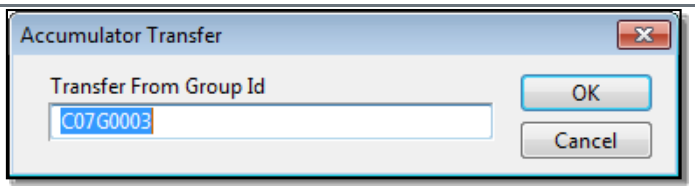


Field		Description
Fields denoted with an * are required.		
Suffix		Indicates the Accumulator Suffix ID.
Type		Indicates the type of Accumulator; i.e. COB, Deductible or Limit.
Number		Indicates the Accumulator Number.

Transferring Accumulators

Accumulators may be transferred from one group to another.

Step		Transferring Accumulators Procedures
Steps denoted with an * are required.		
1		Select **Alt+A+T**. **OR** Select the **Actions** menu. Select **Accumulator Transfer**. The **Accumulator Transfer** dialog box displays.



Step		Transferring Accumulators Procedures
Steps denoted with an * are required.		
2		Enter a group ID in the **Transfer From Group Id** field. This group ID is the group from which accumulators will be transferred.
3		Select the **OK** button.