Configure Provider Agreements

Facets 5.0
Participant Guide

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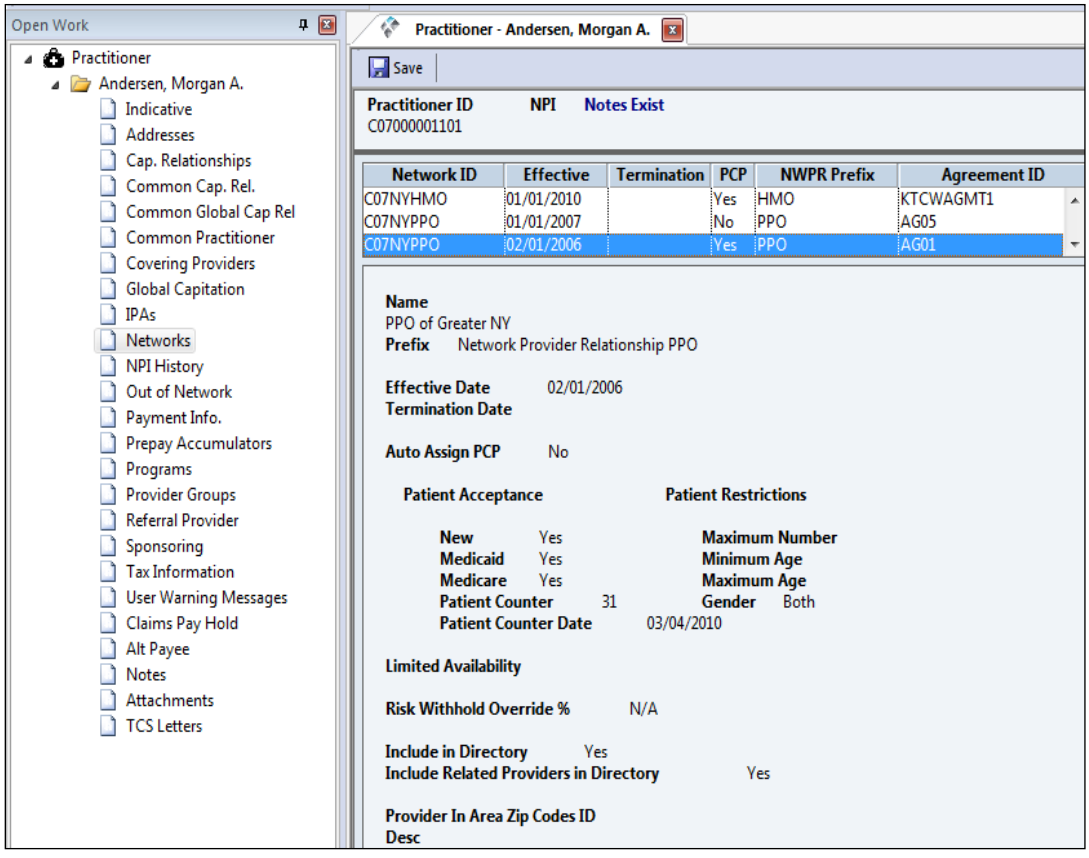
Provider Applications

In any of the four provider type applications (Practitioner, Provider Group, IPA, and Facility), the user may add or edit identifying information about a health care provider who contracts with the MCO to provide health care services to plan members.

Networks Section

This section is used to list all participating networks in which a provider participates. The grid at the top of the section lists the **Network ID**, **Effective,** and **Termination** dates, as well as the **PCP**, **NWPR,** and **Agreement ID** for each network. The area below the grid displays detailed information for the selected row.



Note: A network relationship for a provider must include a Network ID, and NWPR prefix, and an agreement ID. An agreement needs to be created before proceeding.

Agreement, Medical Application (AGAG)

An agreement represents an MCOs contract with a provider (who can be a facility, IPA, provider group, or practitioner). Agreements can vary from provider to provider, or can be shared by all providers in a network. It contains information on how a contract has been negotiated with a provider. This includes establishing rules for that provider's inpatient and outpatient claims, setting up provisions for discounts, risk-withhold, stoploss, special pricing considerations, and determining if a profile pricing exists.

Once the agreement is established, it is attached to a provider's relationship row. While an agreement is usually established to determine in-network benefits, it can also be used to price a provider's out of network claims via the non-participating provider relationship row.

Indicative Section

This section contains indicative information about an agreement between participating providers.

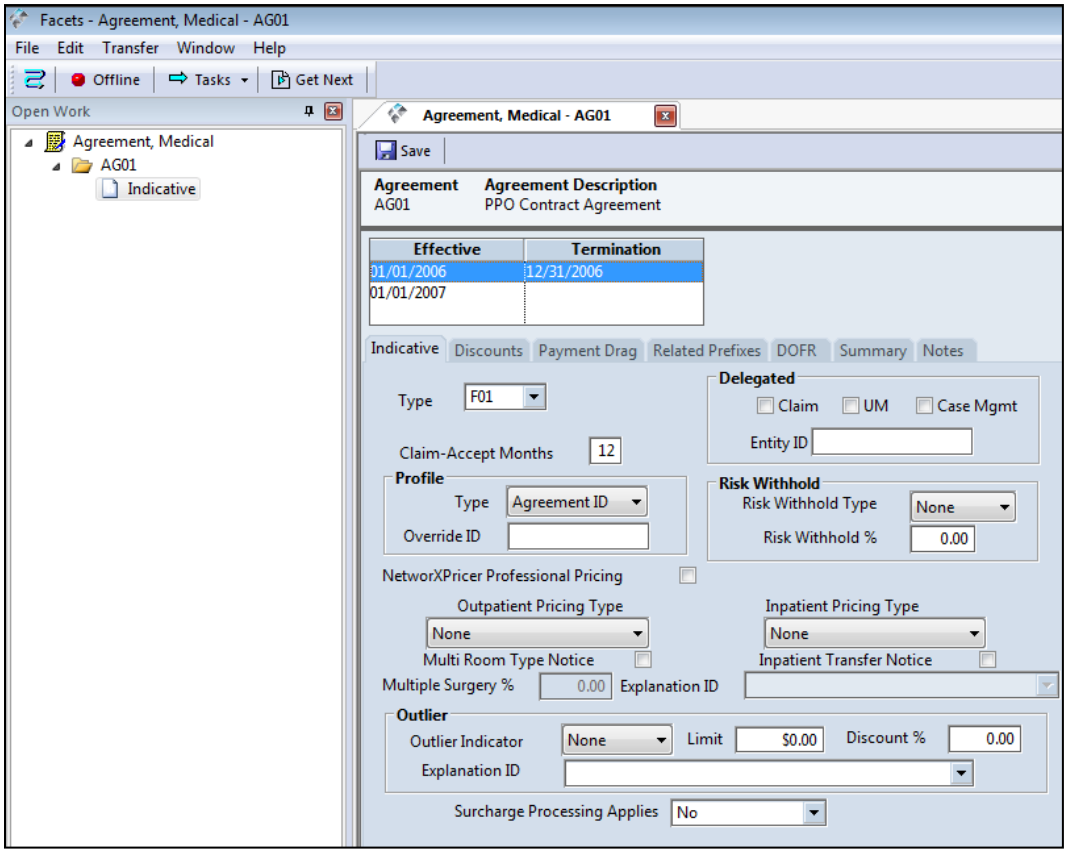
Summary Section Tab

When an existing agreement is opened, this section tab will display. This display-only screen shows all the basic parameters and prefixes that have either been selected or attached to the currently opened agreement. If this is a new agreement, Facets will present the **Indicative** section tab.

Indicative Section Tab

This section tab contains pertinent information concerning Claim Accept Months, Profile ID Type, Risk Withhold information, and attributes related to hospital claims, as well as DRG and All Inclusive or Room and Board Per Diem / Per Case Hospital Pricing.

Once an Effective date has been entered, the user may tab into the **Indicative** section tab to enter indicative information for this agreement.



Field		Description
Fields denoted with an * are required.		
Type		This user-defined code defines the type of pricing attached to the agreement and is used for reporting.
Claim Accept Months	*	Enter the number of months (01-99) after the date-of-service in which the claim was incurred and is accepted for processing for providers linked to this agreement. **Note:** The entry made here on the provider's medical agreement will override the entry made on the Administrative Information (AIAI) product component.
Delegated:		Note: The user must complete the "Delegated" fields in the **Indicative** section tab of the Agreement, Medical application in order to use delegated entity and services functionality in Facets.
Delegated: Claim		Select this box if claim services are delegated for the provider.
Delegated: UM		Select this checkbox if referral or pre-authorization services are delegated for this provider.

Field		Description
Delegated : Case Mgmt		Select this checkbox if case management services are delegated.
Delegated: Entity ID		Enter the Delegated Entity ID (created in the Delegated Entity application of the Provider application group) of the entity used for the delegation of claims, UM and/or case management. This field is required if the user selected the **Delegated Claim**, **UM,** and/or **Case Mgmt** checkboxes.
Profile Type		This field defines how a Pricing Profile that is linked to this agreement will be identified; determines if the Provider ID, Agreement ID or the Network ID will be used to link to a corresponding profile.
Override ID		If a corresponding Profile ID is not linked to a Provider, Network, or Agreement ID, use this field to enter the Profile ID that will be used to link the profile to the agreement.
Risk Withhold Type		Indicates if risk withholding is to be taken off the allowable or paid amount. Facets will not apply a Risk Withhold to be taken off an allowable amount onto a Paid amount. If a risk withhold is done off the paid amount, final calculations are performed during batch.
Risk Withhold %		Percentage applied to the allowable or paid amounts during Risk Withhold calculations.
NetworX*Pricer* Professional Pricing		Select this checkbox to have those claims processed under this medical agreement use NetworX*Pricer*. This field allows the user to specify that pricing will occur through the NetworX*Pricer* for pricing professional claims under this agreement. When the **NetworXPricer Professional Pricing** checkbox is selected, all claims processed under this agreement are processed via NetworX*Pricer*.
Outpatient Pricing Type		Define the specific type of pricing used during hospital claims processing (outpatient). Pricing options include: None, NetworX*Pricer*, DRG/Per Case/Per Diem, DRG Pricing, Per Diem/Per Case, Per Case (All Inclusive), Per Case (Non Inclusive), All-Inclusive Per Diem, R&B Per Diem, ASC Pricing, Ambulatory Payment Classification, Multiple Surgery,

Field		Description
		and NYS Ambulatory Patient Group. **Note:** It is recommended that the **Multi Room Type Notice** not be checked if Multiple Surgery is selected as the Outpatient Pricing Type.
Inpatient Pricing Type		Define the specific type of pricing used during hospital claims processing (inpatient). Pricing options include: None, NetworX*Pricer*, NetworX*Pricer*/DRG, DRG/Per Case/Per Diem, DRG Pricing, Per Diem/Per Case, Per Case (All Inclusive), Per Case (Non Inclusive), All-Inclusive Per Diem, and R&B Per Diem.
Multi Room Type Notice		Used if multiple room types are keyed on a hospital claim. Checking this box will cause a warning message to appear during claims processing if multiple room types exist on a single claim. **Note:** It is recommended that the **Multi Room Type Notice** not be checked if the Multiple Surgery is selected as the Outpatient Pricing Type.
Inpatient Transfer Notice		Checking this box will cause a warning message to appear during claims processing if a patient was transferred to a different inpatient facility. The discharge status must be either 02 (discharged / transferred: other IP facility) or 04 (discharged /transferred: ICF).
Multiple Surgery %		Required if the **Multiple Surgery** option was selected in the **Outpatient Pricing Type** field. Enter the percent that the first/primary surgery should be processed against.
Explanation ID		Required if the **Multiple Surgery** option was selected in the **Outpatient Pricing Type** field and a Percentage was entered in the **Multiple Surgery %** field. Select the user-defined explanation ID that will appear on the EOP if the **Multiple Surgery Outpatient Pricing Type** selection is made and a line item is disallowed.
Outlier Indicator		Determines how to pay charges outside of the usual DRG limits. Used only for DRG, Per Case/Per Diem, and DRG/Per Case/Per Diem claims, Facets checks to see if charges exceed the Outlier limit. For DRG claims only, Facets will also see if the hi/lo trim points for the DRG have been exceeded. If yes, and if the

Field		Description
		Outlier Indicator is set to **Charges** or **Discount**, Facets will perform the appropriate pricing calculations. If the Outlier Indicator is set to **Per Diem** or **New DRG**, Facets will look to the DRG Rules for appropriate pricing.
Outlier Limit		Dollar limit that applies to the outlier by which Facets will verify if charges on the claim exceed the indicated limit amount.
Outlier Discount %		Straight hospital discount; sets the discount amount that will be used if the outlier indicator is set to "Discount."
Outlier Explanation ID		The code and description that will display during claims processing when agreement level outlier pricing methodology is used and a disallow amount is created.
Surcharge Processing Applies		Select whether and how surcharge processing applies when this agreement is used in claims processing based on the provider's relationship to a network. If 'yes', the rules established in the Surcharge Parameters application will be applied during adjudication. Valid values include: 'blank' – No, A – All services, and L – Lab services only.

Discounts Section Tab

This section tab will identify the various discounts that may be applied to a claim when Facets is determining the allowable amounts for services listed on the claim.

Payment Drag Section Tab

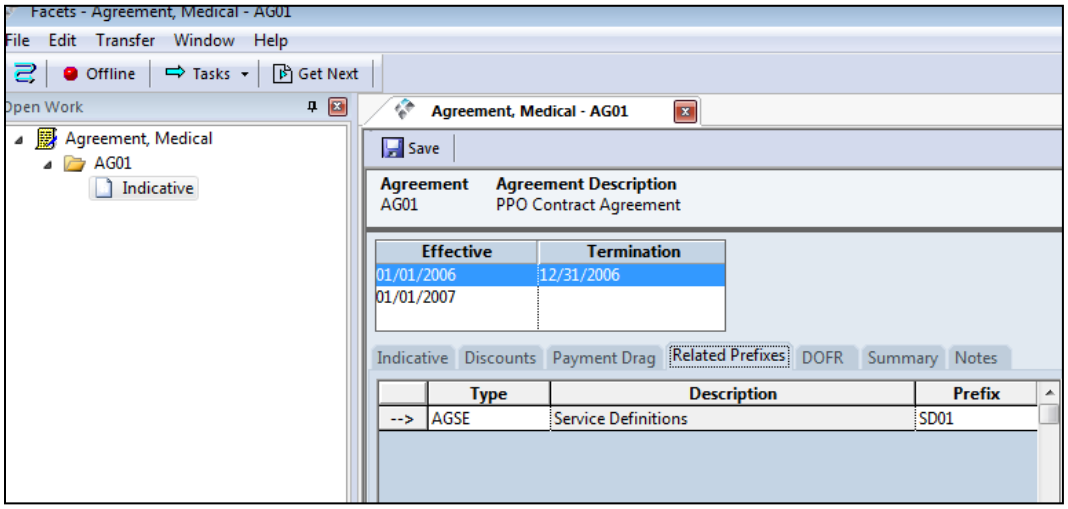
For providers linked to an agreement, this section tab indicates how often claims should be processed for payment.

Note: Payment drag may be set at the Administrative Information-level (AIAI) or at the agreement level. Drags established at the agreement level override those on the AIAI.

Related Prefixes

Related Prefixes Section Tab

This section tab identifies prefixes of different Medical Agreement applications that have been attached to the agreement and will be referenced during claims and/or UM processing.



The Related Prefix IDs may be shared among various agreements***Note:** The Service Definition is a required related prefix. The other prefixes are not required, but may be added if they apply to the agreement.

Service Definition Application (AGSE)

The Service Definition application is the basis for pricing and member benefits. It is the only required prefix for an agreement. The Service Definition on the agreement is provider-specific versus the Service Definition on the Product, which is the default. The Service Definition table allows different referral, preauthorization, capitation, and risk withholding requirements to be applied to all providers accessing this agreement.

Indicative Section

This section allows the user to view or edit service requirements specific to either a product and/or a provider agreement.

Note: Refer to the *Core Facets Pricing* materials for a more detailed description of the Service Definition application.

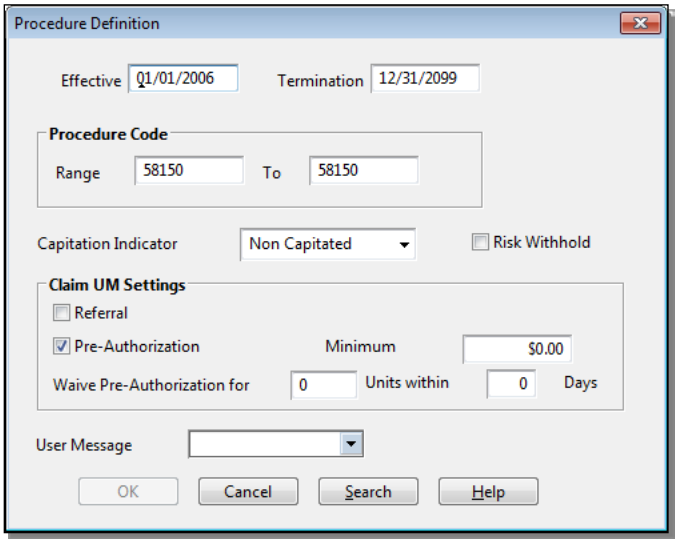
Note: After creating the Service Definition for a provider, the prefix is attached to the provider's Agreement, Medical application in the **Related Prefixes** section tab using the Type of AGSE.

Procedure Application (AGIP)

The Procedure application is used to identify agreement requirements at the procedure level. Procedure codes (CPT-4 codes/HCPCS codes) are universal codes that identify different services that can be performed by a provider, and are used to set-up evaluation, admission, and clinical editing criteria, establish plan pricing structures, and capture utilization review, risk withholding, and capitation information. The prefix is attached to the provider's Agreement, Medical application in the **Related Prefixes** section tab.

Indicative Section

This section identifies the range of procedure codes requiring information specific to claims or UM reviews, risk withholds, or capitation. The grid at the top of this section lists the effective date, low procedure code, referral, pre-authorization, capitation, and risk withhold information. The user may view whether or not referrals or pre-authorizations apply to the specified procedure code range in the selected row, and whether or not a waiver applies to the pre-authorization setting.



Field		Description
Fields denoted with an * are required.		
Effective date	*	Facets will compare this date to the Service From and Service To dates on the claim during processing. **Note:** An error message will display during claims processing if Facets tries to process a line item that has effective and termination dates that span a procedure row. If this occurs, create an additional line item with dates that do not overlap.

Field		Description
Termination date		Termination date for this procedure row.
Procedure Code: Range	*	Lowest number in the range of standard CPT-4 codes for this medical procedure row.
Procedure Code: To	*	Highest number in the range of standard CPT-4 codes for this medical procedure row.
Capitation Indicator		Select to indicate if capitation applies to this procedure code or range of codes.
Risk Withhold		Check this box if a risk withhold should be applied to this procedure code or range of codes.
Claim UM Settings:		Information entered in these fields allows the user to apply UM requirements and parameters to procedures that are accessed for services provided by providers linked to this agreement.
Claim UM Settings: Referral		Check this box if a referral is required for this procedure code or range of codes.
Claim UM Settings: Pre-Authorization		Check this box if a pre-authorization is required for this procedure code or range of codes.
Claim UM Settings: Minimum charge		Enter the threshold dollar amount that requires pre-authorization for this procedure code range. **Note:** This field is enabled if the **Pre-Authorization** checkbox has been selected.
Claim UM Settings: Waive Pre-Authorization for _ Units		Numeric from 0-99. Enter the number of units that pre-authorization requirements will be waived for the specified number of days.
Claim UM Settings: Waive Units within _ Days		Numeric from 0-9999. Enter the number of days that pre-authorization requirements will be waived for the specified number of units.
User Message		Select a user-defined warning message to appear during claims and UM processing if additional review is required.

Note: The Procedure UM Definition application (IPMC) allows users to establish UM requirements and parameters at the plan-level.

Pre-authorization Hierarchy

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

Provider with an Agreement

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

Out of Network (no agreement)

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

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

Adding the Agreement to the Provider

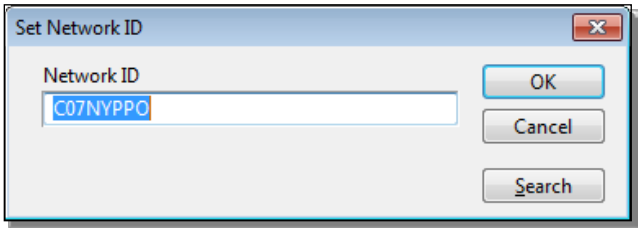
In any of the four provider type applications (Practitioner, Provider Group, IPA, and Facility), the user may add or edit identifying information about a health care provider who contracts with the MCO to provide health care services to plan members.

Networks Section (related to Steps 1, 3 below)

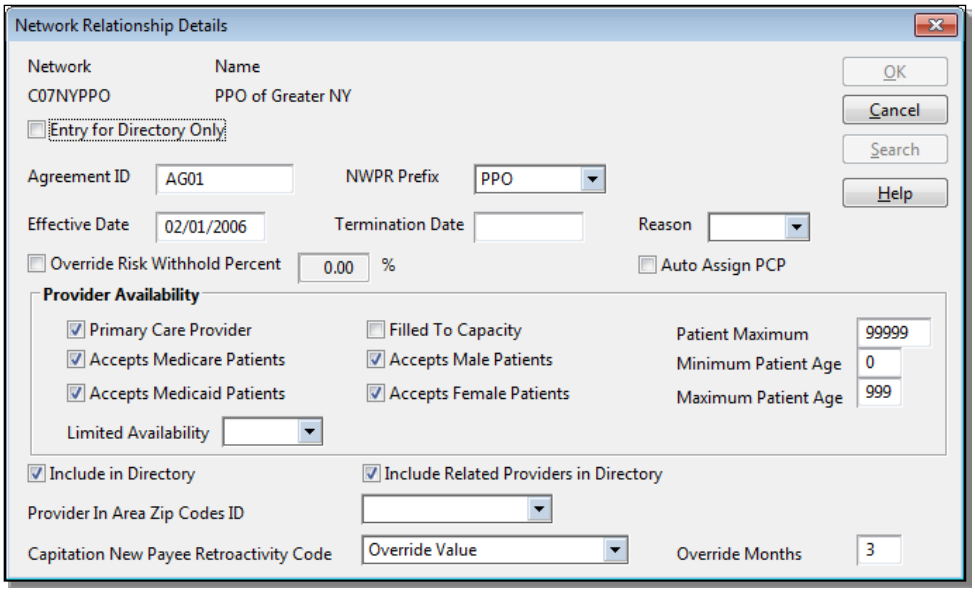
This section is used to list all participating networks in which a provider participates. The grid at the top of the section lists the Network ID, effective and termination dates, PCP, NWPR, and agreement for each network. The area below the grid displays detailed information for the selected row.

Adding Network Information for a Provider

Step	Adding Network Information Procedures
1	From the **Networks** section of the provider's record, select **Alt+E+A**. The **Set Network ID** dialog box displays.



Step	Adding Network Information Procedures (continued)
2	Enter a Network ID.
3	Select **OK**. The **Network Relationship Details** dialog box displays.
4	Complete or change the information in the dialog box, as described in the following description table.
5	Select **OK**. The information entered displays in the grid in the **Networks** section.



Field		Description
Fields denoted with an * are required.		
Network ID	*	Shown as text-out information at the top of this dialog box. This is the ID of the Network the provider is affiliated with.
Name		Network name or description (text-out information).
Entry for Directory Only		A checkbox that triggers Facets to perform online edits for directory purposes only. The values entered in the dialog box will not be stored in the database or used for claims processing.
Agreement ID	*	The Agreement ID used during claims processing when the servicing provider matches the current row and a row in the Network Set.
NWPR Prefix	*	The NWPR (Network Provider Relationship) ID assigned. This links a provider and their agreement to one or more product structures and identifies the proper pricing arrangement.
Effective Date	*	Effective date of the Provider/Network relationship.
Termination Date		Termination date of the relationship between the Network and the provider. Facets allows exception pricing for non-PCP specialists. A

Field		Description
		product parameter, AGAG_HIERARCHY, enables users to indicate that global capitation situations direct Facets to look for a pricing agreement earlier in the adjudication process. Users may sort based on Termination Date. This functionality is available in the following Provider applications: Facility, IPA, Provider Group, and Practitioner.
Reason		If a termination date is given, the user must select a termination reason.
Override Risk Withhold with %		Indicates the risk withhold percentage to be taken during claims processing. The percentage will override what was entered on the medical agreement linked to the servicing provider.
Auto Assign PCP		Select this box to make the provider eligible for automatic PCP assignment. When this box is selected and the provider is a PCP, the provider is eligible for auto PCP assignment. This field displays in the text-out area below the **Networks** section grid.
Provider Availability:		Select the options to indicate if the provider is a PCP, accepts Medicare and Medicaid patients, panel is filled to capacity, accepts males and females, the number of patients in panel, and the minimum/maximum patient ages for the provider.
Limited Availability		Select the user-defined reason to display when PCP selection is not allowed. This reason displays in the Enrollment, Mass PCP Change, and Subscriber/Family applications during PCP selection when the PCP is not available for selection.
Include In Directory		Include the provider with this Network Relationship in the directory.
Include Related Providers in Directory		Include providers related to this provider in the directory.
Provider In		Select the ID for the set of Provider In Area Zip

Field		Description
Area Zip Codes ID		Codes to be linked to this provider. **Note:** This pertains to the Facets Assigned Risk Module; DOFR (Division of Financial Responsibility).
Capitation New Payee Retroactivity Code		Select which new payee retroactivity limit should be employed for this provider. If the user selects "O – Override value," tab to the next field to enter the number of override months.
Override Months		Required when the Capitation New Payee Retroactivity Code is "0" (Override value). When the value selected in the **Capitation New Payee Retroactivity Code** field is "0", enter the overriding retroactivity limit in number of months for this provider. Valid values include: 1-999. A "0" value causes the Capitation Allocation batch to allocate for only the current month (paydate for the cycle) and not process retroactivity. **Note:** These two fields default to "D" (default to the product value) and "999." They are unavailable for entry when the product parameter LIMIT_RETRO_BY_PDPD is set to "No" (retroactivity adjustments are not limited). Refer to the System Administration User Guide for more information about product parameters. **Note:** These two fields pertain to capitation.

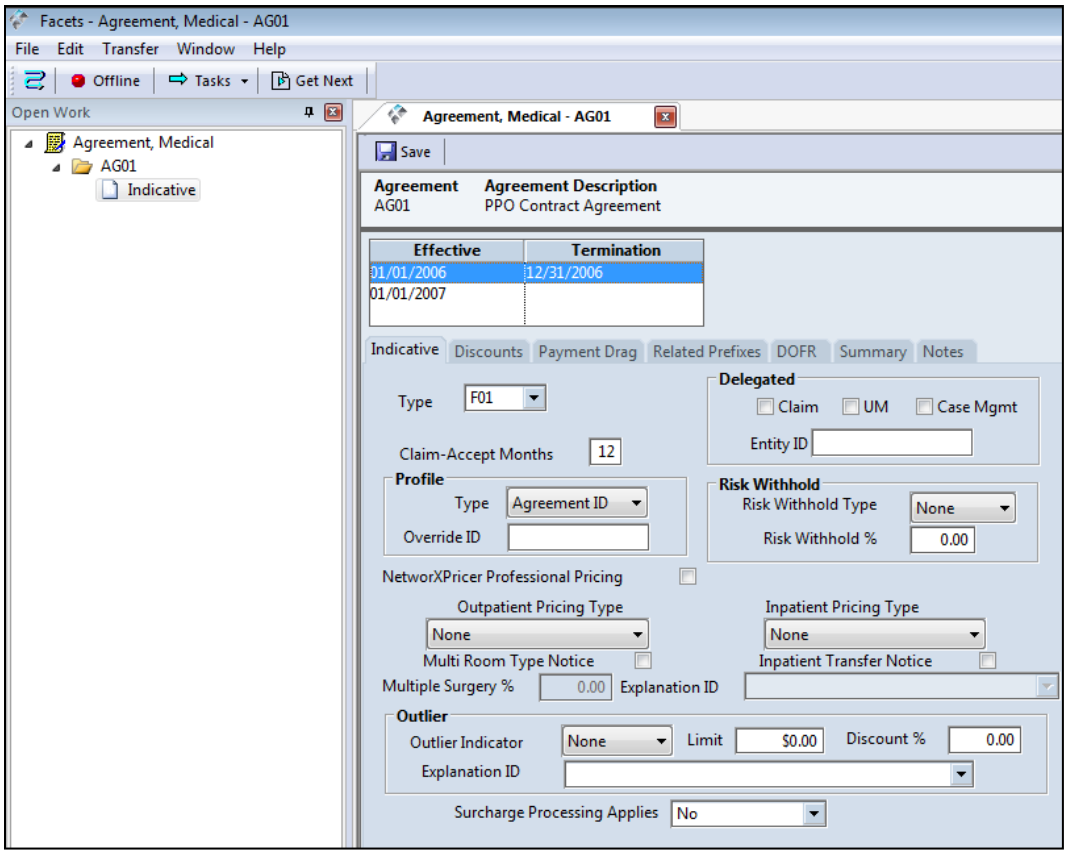
Profile Pricing

The Fee Schedule Profile application stores fee amounts for specific procedures and is used to pay a provider a different amount for those indicated procedures. A schedule amount must be established on the product for each procedure code to be used in a provider's profile. This application may be used with both Schedule and Reasonable & Customary pricing arrangements. This application may also be established for a specific provider, all providers in a network or all providers linked to a specific agreement. Facets will pay the profile amount set-up here, if previously indicated on the Service Pricing record. This application is linked to the provider's agreement in the **Indicative** section tab.

Agreement, Medical Application

Indicative Section

Indicative Section Tab

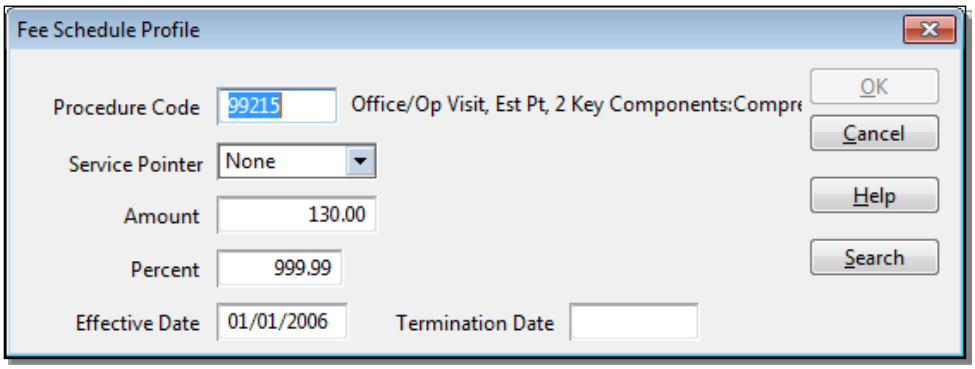


Fee Schedule Profile, Medical Application

Indicative Section

This section displays the service pointer, procedure, and active dates for a specific medical fee. Select a row in the grid to view details of the procedure code in the text out area below the grid.

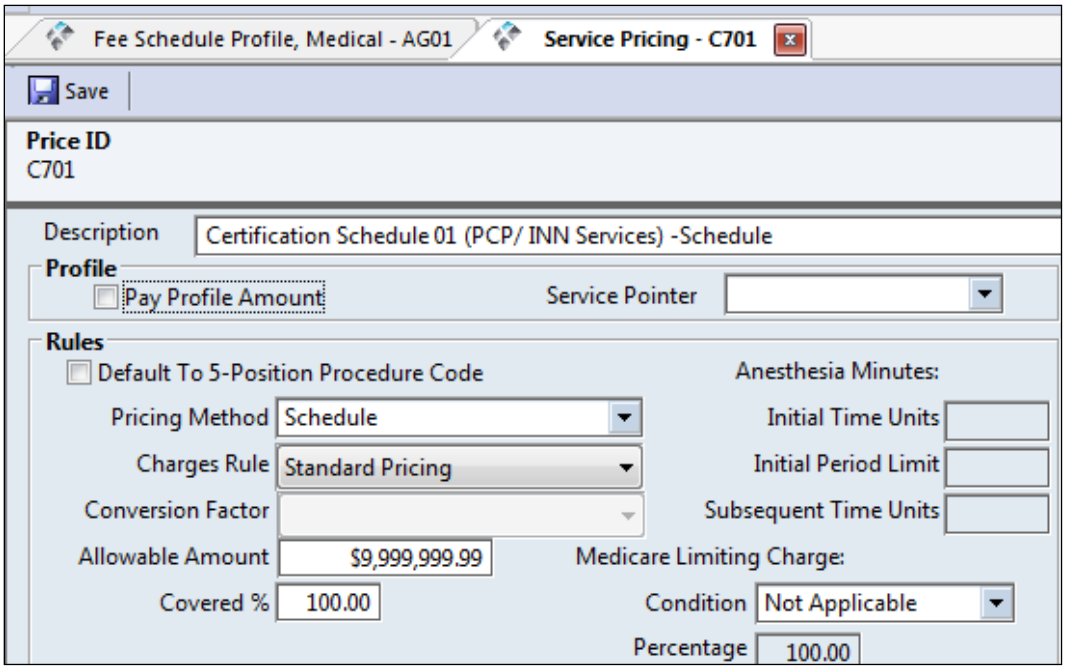
Note: If NetworX*Pricer* is utilized, this application provides no functionality in the pricing routine and should not be utilized. Instead, the Medical Fee Schedules application from the NetworX application group should be used, and specific Fee Schedule Types would be selected to perform profile pricing. This topic is covered in detail in the NetworX*Pricer* Overview Integrated Training course.



Field		Description
Fields denoted with an * are required.		
Procedure Code	*	Enter the five-digit (or five plus two-digit modifier) CPT code.
Service Pointer		If this price refers to the service in a particular instance, a service pointer can be specified. This pointer should match the Service Pointer on the pricing record.
Amount	*	Enter the profile price for this procedure.
Percent		Enter the percentage to be taken against charged amount for this procedure code.
Effective Date	*	Enter the effective date of the price.
Termination Date		Enter the last date this price is valid.

The Service Pricing application indicates the Pricing Method used to price the service, as well as additional prefixes necessary to perform the pricing method. The pricing

record also indicates if a Fee Schedule Profile amount should be used as the allowable price for the service.



If the **Pay Profile** checkbox is selected, the Fee Schedule Profile ID will be found in the **Indicative** section tab of the medical agreement that was linked to the servicing provider. (The Fee Schedule Profile ID can either be a user-defined name or the same name as the Agreement ID, the Provider ID, or the Network ID).

Once the price is found for the service on the Fee Schedule Profile application, Facets uses the **Charges Rule** field on the Service Pricing application to determine if the profile price will be strictly used as the allowable price.

The Charges Rule will either indicate “Standard Pricing” (pay the lesser of) or “Pay the Allowable”.

Note: If NetworX*Pricer* is utilized, the **Pay Profile Amount** checkbox on the Service Pricing record has no functionality.

Note: The information on this page is only used for clients who strictly use core Facets Pricing, not NetworX*Pricer*.

NetworX*Pricer* Medical Agreement Configurator Reference Guide

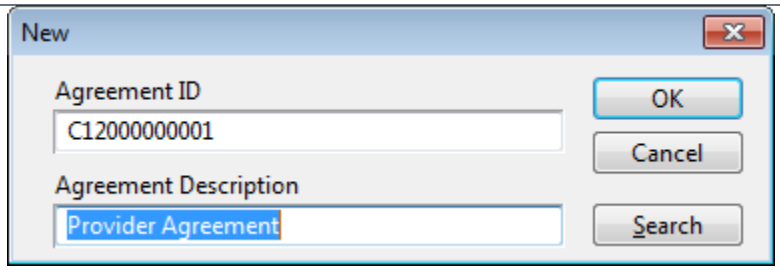
How to Create a NetworX Medical Agreement

The Medical Agreement Configurator application allows users to create and/or maintain medical agreements and view all the component information attached to a specific agreement.

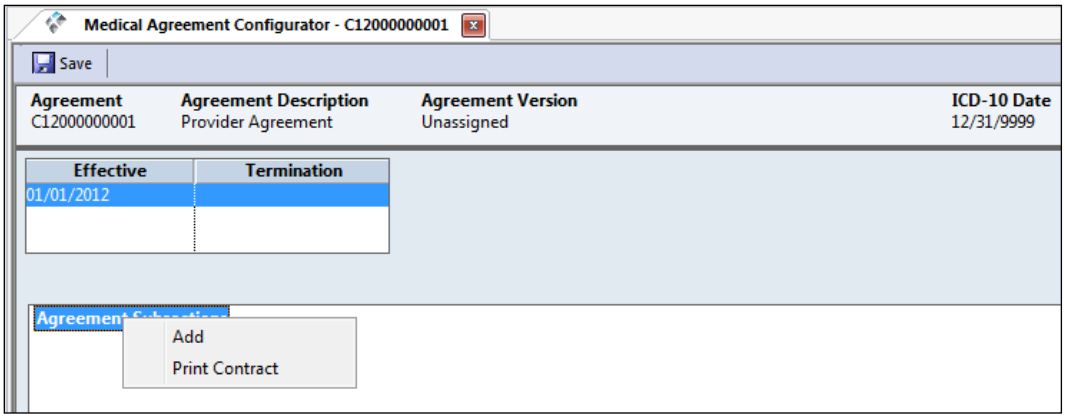
Note: The **AGSE/Service Definition** and **Pricing Type Agreement** subsections are required for a NetworX contract.

Creating a NetworX Medical Agreement

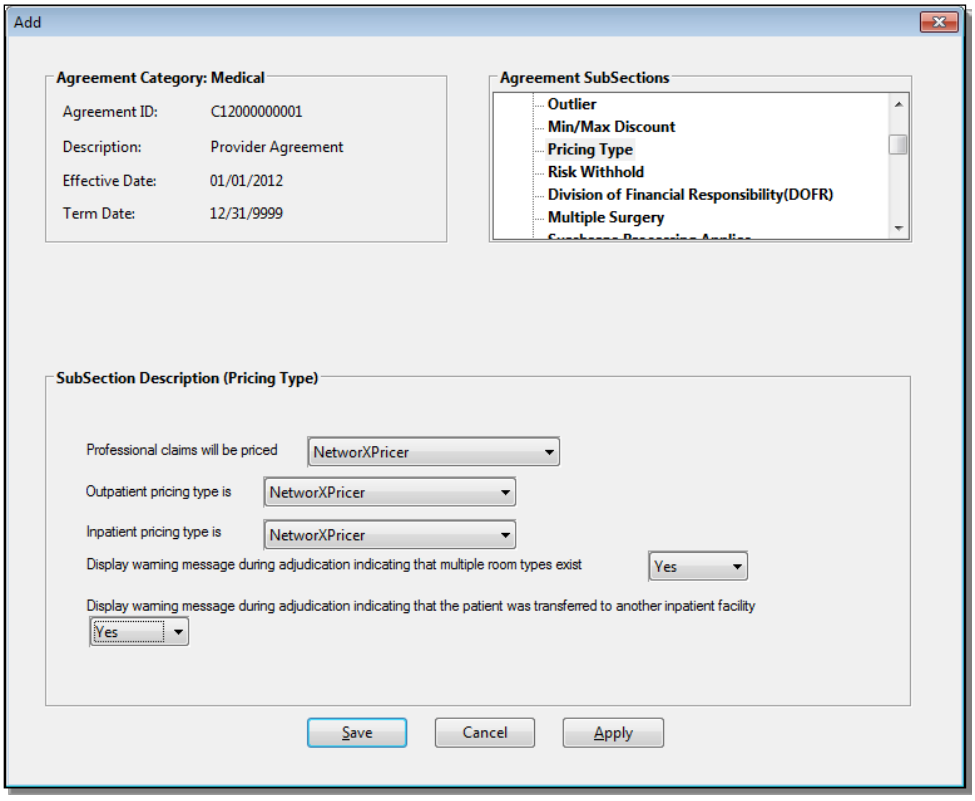
Step	Creating a NetworX Medical Agreement Procedures
1	Expand the NetworX application group.
2	Select/open the Medical Agreement Configurator application.
3	Select **New** from the **File** menu (**Ctrl**+N).



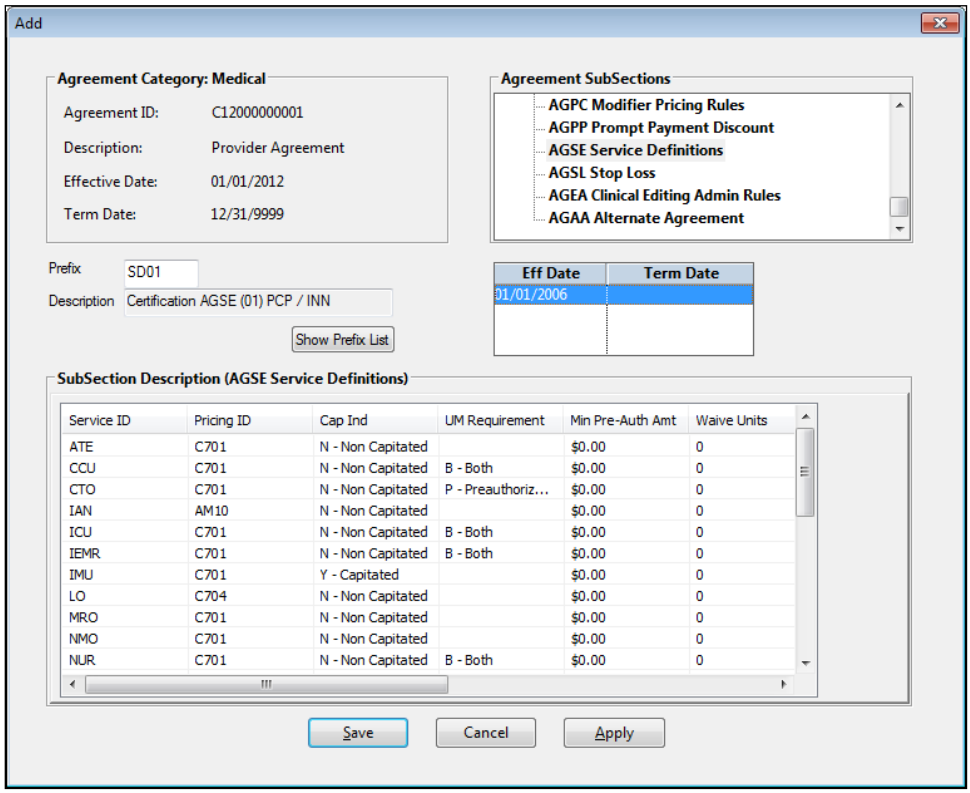
Step	Creating a NetworX Medical Agreement Procedures (continued)
4	Complete the **Agreement ID** and **Agreement Description**.
5	Select **OK** to create.
6	Select **Add**…**Section** from the **Edit** menu (**Alt+E+A+S**).
7	Complete the **Effective Date** (required, in MM/DD/YYYY format) and **Termination Date** fields in the **Add** dialog box. **Note:** If these fields are left blank, a system-generated date of "12/31/9999" is inserted.
8	Select **OK** to add the dates to the Agreement. A new label appears for **Agreement Subsections**.
9	Right click on the **Agreement Subsections** label and select **Add**.



Step	Creating a NetworX Medical Agreement (continued)
10	In the **Add** dialog box, select **Pricing Type** from the **Agreement Subsections**.
11	Select **NetworXPricer** in the **Outpatient pricing type is** field.
12	Select **NetworXPricer** in the **Inpatient pricing type is** field.



Step	Creating a NetworX Medical Agreement Procedures (continued)
13	Once the fields are complete, select **Apply**.
14	Scroll down in the **Agreement Subsections** list and select the AGSE Service Definition.



Step	Creating a NetworX Medical Agreement Procedures (continued)
15	Enter the appropriate Service Definition Prefix in the **Prefix** field. **Note:** To view data in the lower **Service Definition** grid, select the actual Effective Date value.
16	When complete, select **Save**.

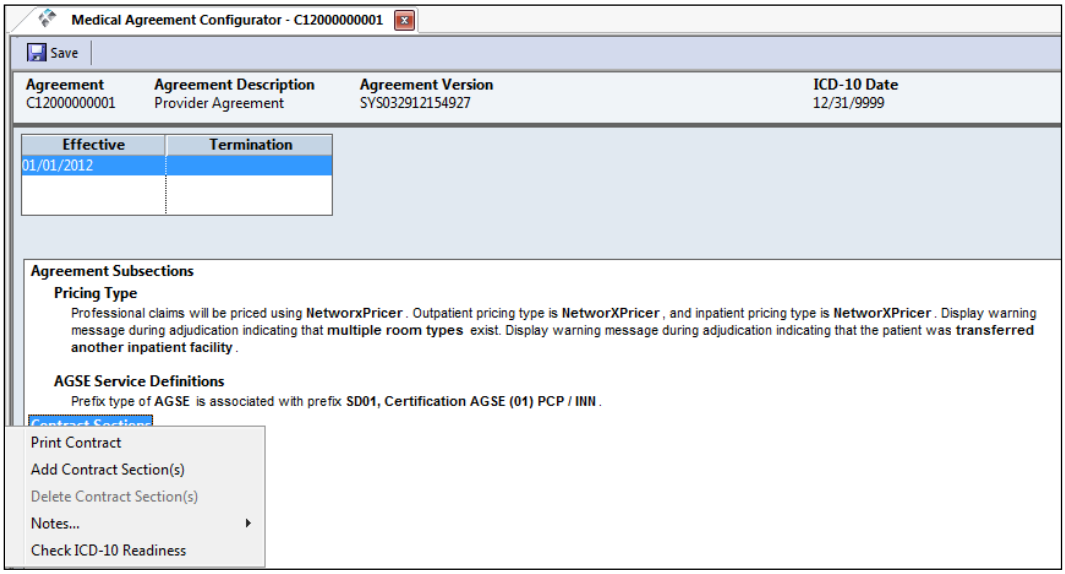
Note: If the two required subsections are not identified in the **Agreement Subsections**, Facets will not display the **Contract Sections** label. If none of the pricing types indicate "NetworX*Pricer*," the **Contract Sections** label will not display.

How to Add Contract Sections to an Agreement

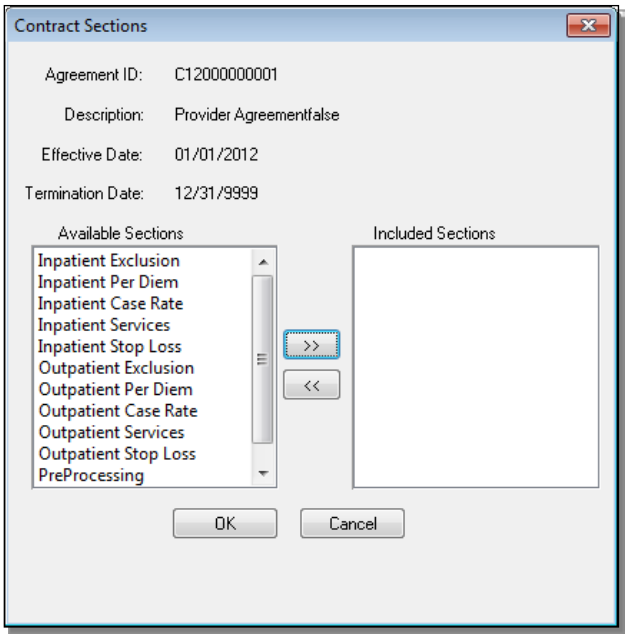
This section is used to create and/or maintain Contract Terms. This allows clients to define the Pricing Methodology used to price services.

Adding Contract Sections to an Agreement

Step	Adding Contract Sections to an Agreement Procedures
1	Right click on the **Contract Sections** label.
2	Select **Add Contract Sections**.

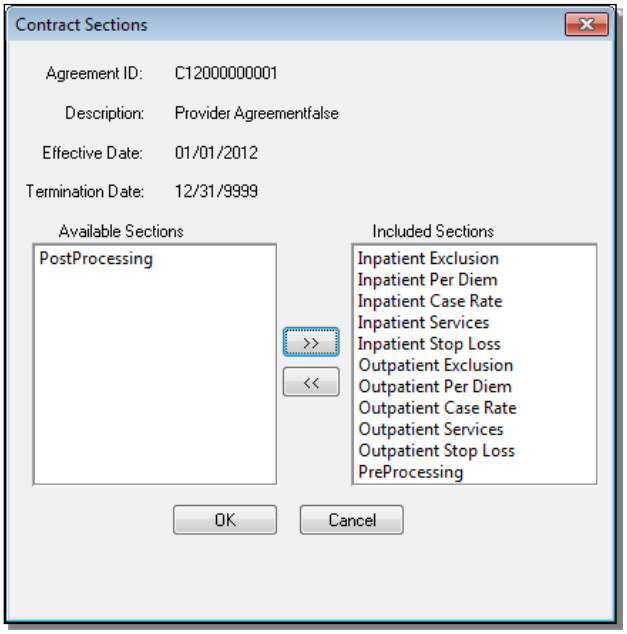


Step	Adding Contract Sections to an Agreement Procedures (continued)
3	The **Contract Sections** dialog box appears.



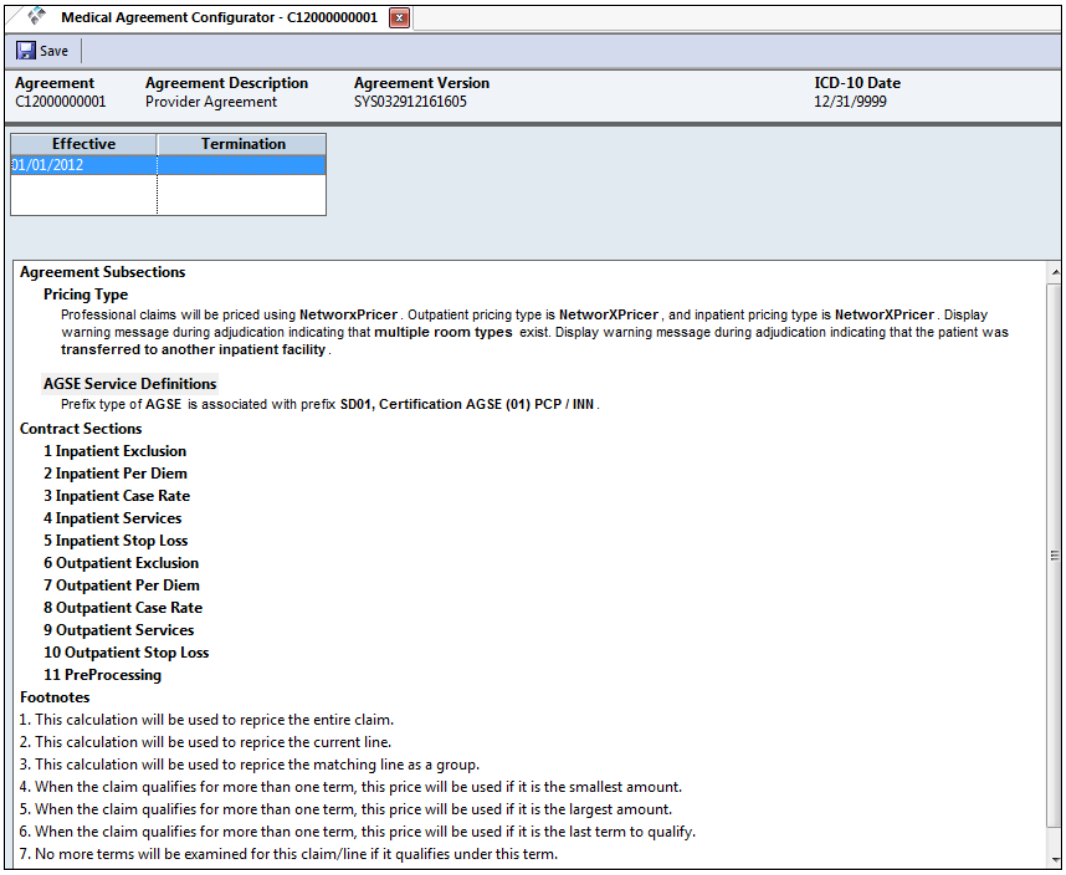
Step	Adding Contract Sections to an Agreement Procedures (continued)
4	Select **Sections** from the **Available Sections** list.
5	Select the **>>** button to move the selected sections to the **Included Sections** list.

Note: It is recommended to add all 11 sections listed in the dialog box screen print below. The order of sections may be changed by selecting and moving one section at a time.



Step	Adding Contract Sections to an Agreement Procedures (continued)
6	When complete, select **OK**. Repeat as necessary.

Note: The selected sections are listed in the Agreement in the order of which they were selected in the **Contract Sections** dialog box. The order in which the sections are listed is not necessarily the same as the processing order. The processing order of sections is always the same regardless of the order the sections are listed.



The sections are now ready to receive terms.

Note: Footnotes become visible when sections are added to the agreement. All footnotes always display at the bottom of every agreement.

How to Add Terms to a Contract Section

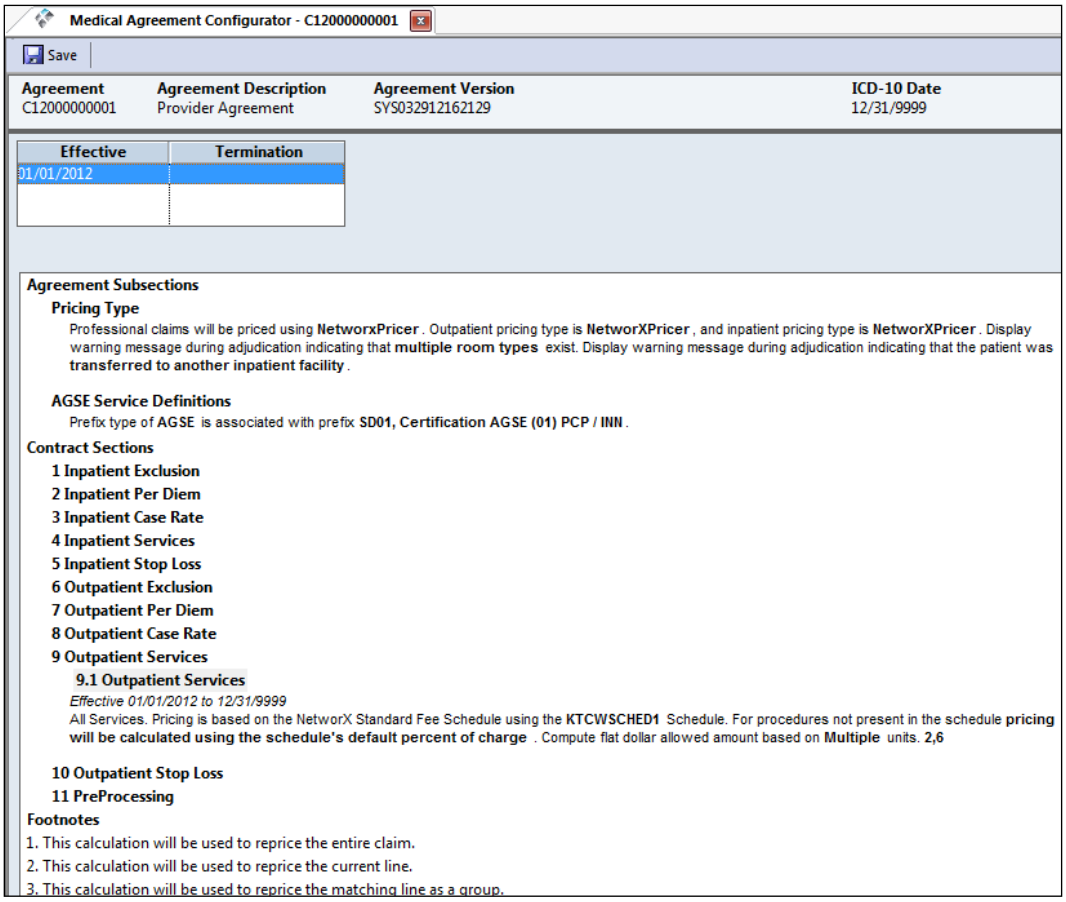
Terms are used to price a service that matches the **Contract Section** and term qualifiers. When a claim line goes through the pricing engine and qualifies for a term, it will price in accordance to the calculation identified in the term.

Adding Terms to a Contract Section

Step	Adding Terms to a Contract Section Procedures
1	Right click on the label of the section where the term will be added.
2	Select **Add**.
3	The **Insert Term** dialog box opens. The position of the new term is now indicated in the title bar.
4	Enter the required fields: **Description**, **Effective Dates**, **Qualifications,** and **Calculations**.
5	Enter specific calculation values in the template.

Note: Term logic displays at the bottom of the dialog box after selecting a calculation bean.

Step	Adding Terms to a Contract Section Procedures (continued)
6	Enter any optional term fields: **Explanation** - Enables the use of Facets explanations regarding this Term (on EOB/EOP, for example). **User Message** - Enables the use of Facets messages and their powerful security levels on this Term. **Complex Qualifier** - Used rarely, primarily to maintain older agreements. Its use for new agreements is discouraged. Complex Qualifier Groups have largely replaced this function. **Complete** - Used to stop the NetworX pricing processing flow when this term prices a claim line/claim. If “Complete” is checked, Footnote 7 is included in the Term footnotes.
7	Select **OK** to save the term and return to the agreement view. The new term is added to the appropriate section.



Note: The Term ID (e.g. 9.1) is system-generated. Term order and location can be changed by right clicking on the Term Label and selecting **Copy Term**. Then select the Term above the location for the moved Term and select **Paste Term**. Alert messages will appear if calculations are not appropriate to the section where the term is pasted.

Related Prefixes to use for Facets and NetworX Agreements

The following are Related Prefixes used with a NetworX Agreement (Medical Agreement Configurator) and CORE Facets Agreements (Agreement, Medical):

NetworX and Facets Agreements

- AGRT (Auto Room Type)
- AGAA (Alternate Agreement)
- AGEA (Clinical Editing Admin Rules)
- AGCB (COB Rules)
- AGDC (Delegated Services-Claims)
- AGDU (Delegated Services-UM)
- AGIP (Medical Procedure Definition)
- Payment Drag
- Pricing Type
- Profile Type
- AGPP (Prompt Payment Discount)
- Risk Withhold
- AGSE (Service Definition)

Facets Agreements only

The following Related Prefixes are used in CORE Facets agreements:

- AGHI (ASC Multiple Procedure)
- Min/Max Discount
- AGRG (DRG Rule)
- AGPD (Exclusions)
- Inlier
- AGPC (Modifier Pricing Rules)
- Multiple Surgery
- Outliers
- AGSE Stop Loss