Acronyms Quick Reference Guide

The following quick reference table of acronyms represents various Facets applications and sections. These applications are used to create product component files, related agreement prefix files and various configuration files. This list is sorted alphabetically by acronym:

Acronym	Name	Description
ACIN	Claim Interest Rates	Identify the interest rate to be applied to each claim that has been categorized as not being processed within a pre-defined time period that is established on the corresponding Product.
AEID	AE Criteria by Diagnosis	Administer the clinical review diagnosis criteria used to support authorization decisions.
AEIP	AE Criteria by Procedure	Administer the clinical review procedure criteria used to support authorization decisions.
AGCB	COB Rules – (Agreement)	Define coordination of benefits rules that Facets will apply during claims processing. If this prefix has been established and attached to a Medical Provider Agreement, it will apply to all providers attached to that agreement.
AGDC	Delegated Services – Claim	This application allows the user to identify the services that are delegated for claims processing.
AGDU	Delegated Service – UM	This application allows the user to identify the services that are delegated for UM processing.
AGHI	ASC Multiple Procedures	Specify details of the provider agreement related to multiple services performed at an Ambulatory Surgery Center or hospital outpatient department. This prefix is attached to the Medical Provider Agreement.
AGIL	Inlier	This application allows the user to define a different pricing methodology for the claim if the total billed amount is less than a pre-defined percent of the threshold.
AGIP	Medical Procedure Definitions (Procedure)	Define agreement prefix requirements specific to procedures that are accessed for services performed by related providers. For example, within the surgery service code, only certain procedures will require referrals. This prefix is attached to a Medical Provider Agreement.

Acronym	Name	Description
AGPC	Modifier Pricing Rules	This application allows the user to enter pricing rules for each modifier. Information entered here is used in conjunction with the Modifier Hierarchy application (found in the Application Support application group) to determine the final line item price. This application allows the user to specify a percentage and action to take when specific modifiers appear on a line item in a position other than first.
AGPD	Exclusions	Define specific service(s) excluded from the standard agreement pricing contract. This prefix is attached to a Medical Provider Agreement.
AGPP	Prompt Payment Discounts	Define prompt payment discount criteria for claims for a provider's services that are processed in a timely manner. This prefix is attached to a Medical Provider Agreement.
AGRG	DRG Rules	Define rules that apply to a DRG code. Each set of DRG rules is identified by one or more unique prefixes in Facets. DRG rules allow the user to determine the benefit amount for hospital claims. This prefix is attached to a Medical Provider Agreement.
AGRT	Auto Room Type	Define room types (categories). Once the user establishes the Auto Room Type prefix, Facets can automatically generate the room type entry that is required to obtain pricing values for per diem and per case hospital claims during Hospital Claims Processing. This prefix is attached to a Medical Provider Agreement.
AGSE	Service Definition	Define information specific to each type of service to be adjudicated during claims processing and utilization management (UM). This prefix is attached to the Provider's Agreement.
AGSL	Stop Loss	Define the stoploss dollar value at which the MCO alters the standard agreement pricing logic to limit their liability on a large dollar hospital confinement. This prefix is attached to

Acronym	Name	Description
		a Medical Provider Agreement.
AIAI	Administrative Information	Define Plan benefits related to claims processing, utilization management processing, warning messages and drag provisions.
ARAR	Administrative Rules	Define the administrative provisions of the Product specific to UM referral and pre-authorization processing.
AUPL	Automatic Payment Levels	Define an automatic payment level prefix and maintain a corresponding set of payment actions for specified services.
BSBS	Benefit Summary	Describe the Product's coverage for a member's Plan, and specify the type of coverage, co-pay, deductible, coinsurance and limit for each benefit.
CBCB / AGCB	COB Rules	Define coordination of benefit rules for coordinating primary & secondary carrier benefits that Facets will apply during claims processing. This prefix will be linked to the product (CBCB) and may also be linked to the provider's agreement (AGCB), which offers the ability to vary COB rules by provider (all claims processed for that medical agreement now adhere to those COB rules). The agreement prefix (AGCB) overrides the product prefix (CBCB).
CECE	Clinical Editing Criteria	Administer clinical editing criteria that may be used when processing medical claims in Facets.
CGPY	Dental Category Payment	Define which dental category payment rules apply to a given Product component prefix.
CGWP	Dental Category Waiting Period	Define the amount of time a member or subscriber must wait before they are eligible for a specified dental procedure.
CLUM	Claims UM Match Parameters	Establish the criteria that define an exact match from a claim to a UM pre-authorization or referral review.
CRCD	CT/SC/DI Criteria	Administer the complexity of treatment, severity of condition and discharge criteria used

Acronym	Name	Description
		during pre-authorization processing.
CRCL	Claim Encounter Mapping	Create a road map of how claims and/or capitation/ risk allocation encounters should be tagged for analysis purposes.
CSPI	Class/Plan Definition	Display the Plan/Products that are available to a specific set of subscribers within a group.
CVST	Covering Provider Set	Establish Product-specific covering providers or vary pricing for covering providers by Class/Plan.
DAER	Dental Clinical Editing Admin Rules	Define actions to be taken when a dental clinical edit is detected. All dental clinical editing logic is based on procedures performed on the same day by the same provider on the same tooth or tooth range.
DECE	Dental Clinical Editing Criteria	Define the criteria to be applied for dental edits. All dental clinical editing logic is based on the procedure performed on the same day by the same provider on the same tooth or tooth range.
DEDE	Deductible Rules	Establish the amount which must be paid by the member, either on a Plan year or lifetime basis, before benefit payment begins.
DIDI	Administrative Rules, Disability	Define Plan benefits related to claims processing, payment rules, warning messages and payment provisions.
DMPD	Pre-determination Match Parms	Create and store a set of parameters used during dental claims processing to match incoming dental claims with existing dental pre-determinations.
DNAR	Administrative Rules / Dental	Define processing rules for dental referral and pre-determination processing.
DNRP	Dental Reward Parameters	The ability to apply reward benefits to the following year based on the prior year utilization. This record provides the ability to roll over or carry over a pre-determined rewards benefit maximum amount when claim payments to a member during a benefit year are below a pre-set threshold amount.

Acronym	Name	Description
DPCG	Dental Procedure/Category Conversion	Define how Facets converts procedure codes entered during claims processing to a category code. The category codes point to payment allowable amounts that are used to determine payment allowable amounts, co-payments and deductibles.
DPDF	Procedure Definition, Dental	Define and link ranges of dental procedure codes to pricing IDs and processing options.
DPIN	Incentive Dental Processing Rules	Standard Incentive Dental increases the coinsurance percentage annually as long as members have preventive dental services performed each year. Progressive Incentive Dental increases the coinsurance percentage annually, regardless if any preventive services were performed. This records allows the user to store the type of incentive dental being processed, the consequences for not having a preventive service performed and a list of those services.
DPPY	Procedure Payment, Dental	Define which dental procedure payment calculation amounts and indicators apply to a given dental procedure during dental claims processing.
DUDN	Duplicate Claim Rules, Dental	Define duplicate claim rules criteria to be used during dental claims adjudication to determine if a duplicate of the claim being processed has already been entered into Facets.
DUFS	Duplicate FSA Claim Rules	Define parameters Facets uses to perform duplicate checking for manually entered FSA claims, and to check automatically generated claims against previously entered manual claims.
DUMD	Duplicate Claims	Define the rules for what constitutes a definite or possible duplicate claim or line item when processing.
DUUM	Duplicate UM Rules	Define the parameters to be automatically applied during the processing of a utilization management review to determine if the current review is a duplicate of a previously processed

Acronym	Name	Description
		review.
EAAR / AGEA	Clinical Editing Admin Rules	Audit medical claims, referrals and pre-authorizations during online processing to ensure consistency between a patient's age and diagnosis, the patient's gender and diagnosis, as well as the link between procedure and diagnosis. May also be attached to the agreement (AGEA), which gives the ability to vary clinical editing at the provider level (all claims processed for that agreement now adhere to those clinical editing rules). The agreement prefix (AGEA) overrides the product prefix (EAAR).
EBCL	EOB Information	Define the Deductible and Limit accumulation to be printed on the explanation of Benefits based on an incurred year or lifetime.
EEPO	Extension Panel	Allows clients the ability to add their custom .NET Embedded Extension panel as a new page to existing Facets apps.
EP11	Extension Panel, Configurable	Users may now configure a custom application to house the Embedded Extension configurable panel and the Related Information component.
EXCD	Explanation Codes	Administer the explanations that are generated throughout Facets to appear on EOBs, remittance advice, etc.
FSAI	FSA Medical Expense Admin Info	Define parameters to govern how Flexible Spending Account (FSA) claims are processed, as well as provide links to the appropriate Duplicate FSA Claim Rules and FSA Expense Categories prefixes.
FSEC	FSA Medical Expense Categories	Define and store items for which FSA reimbursement is eligible on manually processed claims.
GRDC	Debit Card/Bank Relationship	Allows users to integrate Debit Card Intermediary and Debit Card Bank records, creating a prefix to be used by a group/plan for CDH transactions. The prefix created from this application is linked to a plan/product relationship in the Class/Plan Definition

Acronym	Name	Description
		application, which confirms that debit card functionality will possibly be used for CDH transactions.
HCLS	Hospital Claim Classification Mapping	Allows users to map hospital claims by classification.
HBCD	Hospital Bill Code Definition	Identify a type of facility and bill classification combination as either inpatient or outpatient.
HFCD	Hospital Frequency Code Definition	Identify the frequency of the hospital bill for claims processed under a Plan.
HSAI	HRA Administration Information	Used to set the parameters defining how a service should be adjudicated during claims processing when the plan includes an HRA benefit. The application also identifies the Deductible Prefix and Accumulator that is related to an HRA deductible. The prefix associated with this application will eventually be added to the Class/Plan Definition application.
HSAL	HRA Allocation Rules	Used to define the dollar amounts to be allocated by an employer group to a subscriber and their family members. The application will also identify how carryover allocation amounts should be handled, as well as define medical and HRA deductible amounts.
HSQE	HRA Qualified Medical Expenses	Used to list services eligible for reimbursement utilizing HRA benefits. This application is not required for claims processing. It offers a means to display the listed services via a Web user-interface (i.e. Healthweb or eBusiness Suite).
IDCD	Diagnosis Codes	Add diagnosis codes or edit existing diagnosis codes.
IDCR	Diagnosis Edit Criteria	Administer the criteria rules that apply to referrals and pre-authorizations with a specific medical diagnosis.
IDMA	Medical Admission Criteria	Administer admission criteria for a diagnosis.

Acronym	Name	Description
IDPX	Pre-Existing Condition	Identify diagnosis codes that might indicate conditions that existed before a member joined this plan. When a line item with one of the diagnosis codes listed in this application is processed for the member for either Claims or Utilization Management, and the service date falls within the period indicated on the Administrative Information application, Facets will generate a "Possible Pre-Existing Condition" warning.
IPCD	Procedure Codes	Allows users to administer procedure code information.
IPCF	Conversion Factor Definition, Medical	Assign conversion factors to pointers. These conversion factors are used in calculations for Conversion Factor times Relative Value Unit, RBRVS, and Anesthesia pricing.
IPCR	Procedure Edit Criteria	Administer the criteria rules that apply to referrals and pre-authorizations with a specific medical procedure.
IPMC	Procedure UM Definition	This application allows the user to define and maintain a set of UM requirements and parameters at the procedure code level. The user can apply UM referrals, pre-authorizations, minimum pre-authorization amounts and waivers to a set of procedure codes. Facets factors this information into its calculations during claims processing that include any of those procedure codes.
IPRS	R&C/Schedule, Medical	Assign dollar amounts to procedures, and vary the amounts by pointer for fee schedule or geographic area for R&C.
IPRV	Unit Value Pricing Definition, Medical	Assign unit values to pointers. These unit values will be used in calculations for Conversion Factor times Relative Value Unit, RBRVS, and Anesthesia pricing.
IPSA	Surgical Admission Criteria	Administer admission criteria for a surgical diagnosis.
LOBD	Line of Business	Capture the name & address of the Line of Business; identify the entity as indemnity,

Acronym	Name	Description
		HMO, PPO, TPA or other; specify payer associated with this line of business; and define the accounting period.
LSND	Length of Stay by Diagnosis	Administer HCIA Length of Stay data for a diagnosis.
LSNP	Length of Stay by Procedure	Administer HCIA Length of Stay data for a procedure using ICD-9-CM procedure codes.
LTLT	Limit Rules	Define each benefit limitation or stoploss (out of pocket maximum) applicable for a Health Plan.
MCPA	Auto- PCP Assignment Criteria	Identifies a set of automatic PCP assignment criteria and select parameters that will be used to select matching providers for automatic PCP assignment.
MCRD	Automatic Action Criteria	Link the appropriate letter to a business event while identifying matching criteria such as eligibility event, group, Product and batch ID for excluding and including populations.
MCTR	User-Defined Codes	Set-up user-defined codes to be available for selection in various Facets applications and are stored in various database tables.
MDSP	Medicare Supplemental Rules	Allows the user to create a set of Medicare supplemental rules that are then linked to a Product and applied during the processing of a claim for that particular product. The options that may be used for processing medical + hospital outpatient and hospital inpatient claims for a product that includes Medicare Supplemental rules are: reimburse deductible and coinsurance only, reimburse deductible and coinsurance only and subtract Medicare Allowable, disallow, and process normally.
MRFA	CMS Rate Factors (Factors table)	Establish Medicare ages and categories on the Factors table; CMS Rate Factors application (CMS = Centers for Medicare and Medicaid Services).
MRFD	CMS Rate Factors (Indicative section)	Establish the Medicare factor prefix and description, Indicative section, CMS Rate

Acronym	Name	Description
		Factors application.
MRFT	CMS Rate Factors (Gender table)	Establish Medicare gender, effective and termination data on the Gender table, Indicative section, CMS Rate Factors application.
MRMR	M&R Criteria	M&R Inpatient and Surgical Care Guidelines are used to determine the appropriateness of treatment, optimal recovery guidelines and average length of stays for inpatient admissions.
NPPR	Non-Participating Provider Relationship	Create a link to an agreement for a provider who is not in network in order to establish pricing requirements.
NSRS	OON Networx*Pricer* Terms ID	Eliminates the need to create a NPPR prefix to get Facets to recognize an agreement in the Out of Network section of a provider file for Professional Pricing using NetworX*Pricer*. An Agreement also needs to be created using the same 4-character prefix that was used in creating the NSRS component prefix. When the two are identical in prefix, Facets will relate them together and see that the NetworX*Pricer* Professional pricing checkbox has been selected on the agreement.
NWCR	Specialist Relationships or Global Providers	NWCR with the Network capitation Indicator is used to find specialist relationships (capitation and/or fee-for-service). This relationship occurs where every PCP in the network has selected the same specialist for services. NWCR is used to find Global providers (capitation and/or fee-for-service). This relationship occurs regardless of a member's PCP selection.
NWPE	PCP Capitation	NWPE is used to find PCP capitation and secondary specialist relationships (capitation and/or fee-for-service).
NWPR	Network Provider	Used to indicate PCP and Specialist relationships.
NWST	Network Set	Displays all the valid Networks and Network Provider Relationships (NWPR) for a benefit Plan.

Acronym	Name	Description
OLOL	Other Party Liability	Define the Product component for other party liability. The information established here will apply to all claims processed under Plans that use this Product prefix.
PCAG	Processing Control Agent	Establish criteria for automating claims processing workflow and letter generation in Claims and UM. Data may be entered in this application's Criteria section to specify how claims will be processed and when automatic letter generation will occur. Criteria may also be deleted if it is no longer needed.
PDAF	Alternate Funding	Enter and maintain alternate funding rules for a plan.
PDBC	Product (Components)	Identify the specific Product components that Facets accesses during claim or UM review processing on the Components section, Product application.
PDBL	Billing Component	Define and describe the different types of components that are available as part of this billing Product.
PDDS	Product (Indicative)	Define a Product as Medical, Dental or Other, establish its Product type as Medicare or commercial, select a user-defined business category, define an allowable break in enrollment, and perform claim interest calculations for a Product on the Indicative section, Product application.
PDPD	Product (Business Information)	Define primary and alternate lines of business for the appropriate distributions of funds according to the line of business the services rendered applied to on the Business Info section, Product application.
PDRT	Premium Rate Table (Rates)	Identify premium rating age band categories on the Premium Rate Table application, Tiers section.
PDRC	CMS AAPCC Rate Table	Store and maintain Medicare risk rate information.
PDRA	Premium Rate Table	Define premium rate categories based on

Acronym	Name	Description
	(Modifiers)	gender, smoker, and user-defined modifiers for a Product on the Modifier grid, Tiers section, Premium Rate Table application.
PDRA	Premium Rate Table (Indicative)	Describe premium rate tables that are used to determine premiums based upon premium rate ages and rate categories on the Indicative section, Premium Rate Table application.
PDVC	Product (Variable Components)	On the Variable Components section, Product application, identify Product components Facets accesses during claims or UM review processing to determine possible rule violations based on provider selection and UM compliance.
PDVL	Volume Calculation (Indicative)	Establish volume based Product rules such as flat amount, salary based, elected units and minimum/maximum volume amounts that are used to calculate insurance and disability coverage.
PMAR	Volume Reduction Calculation	Used to reduce a premium based on age calculations.
PMCS	Volume Calculation (Child Schedule)	Identify ages and volumes related to dependent children life Products.
PMFT	Area & Industry Rate Factors	Establish a range of area or industry rate codes and apply them to the rating process.
PMTR	Trend Rate Factors	Create and edit trend rate factor information for premium billing.
PMVL	Volume Calculation (Salary Table)	Identify salary ranges and factors which allow volume based Plans to have the associated volume determined by multiple factors of a subscriber's salary on the Salary Table subsection, Indicative section, Volume Calculation application.
PRAC	Provider Accumulators	Add and update provider accumulator balances. The user may also store capitation and claim amounts for each provider.
PRCV	Covering Provider Prefix	With CVST, establish Product specific covering providers or vary pricing for covering providers

Acronym	Name	Description
		by Product.
PRRF	Referral Provider	PRRF is used to indicate referral providers' relationship to a servicing provider.
PSCD	Place of Service Description	Equate a place of service with a user-defined code, and define if the place of service is considered inpatient or outpatient.
RCCT	Service/Revenue Code Conversion	Establish a range of hospital revenue codes for a Product component prefix.
SARX	Service Area Exception	This application allows the user to define that a particular provider, type, modifier or service is always in area or always out of area and therefore, service area calculations are not required. This is part of the Facets Assigned Risk Module.
SCPA	Surcharge Parameters	This application allows the user to establish the surcharge percentage, indicate whether the surcharge should be excluded when the member has Medicare coverage and indicate whether to apply the surcharge to capitated services for a specific date range.
SCQG	Supplemental Conversion Qualifier Group	Configure Qualifier groups for Supplemental Procedure Conversion Rules and Supplemental Revenue Code Conversion Rules applications.
SECT	Service Code Conversion	Establish service conversion to class Product and reporting categories.
SEDF	Service Definition	Define information specific to each type of service to be adjudicated during claims processing and utilization management (UM). This prefix is attached to the Product.
SEDS	Service ID Descriptions	Administer service codes and their descriptions.
SEGR	UM Service Groups	Establish sets of services that would include all the professional components involved in a patient's care and treatment.
SEPC	Service Pricing	Define IDs that point to specific types of pricing. These IDs are linked to types of service via the Service Definition application.

Acronym	Name	Description
SEPY	Service Payment	Tie service rules to types of service. These types of service can be linked to Experience and Accounting Categories for reporting purposes.
SERL	Service Related Parameters (Relationships)	Define information on relationships between types of services, including parameters that must be satisfied in order for the services to relate together during the adjudication process. This is established on the Related Parameters group box, Indicative section, Service Related Parameters application.
SESE	Service Rule Definition (Indicative)	Define information about age, gender and member type requirements, service maximums, co-pays/coinsurance and deductibles on the Indicative subsection, Service Rule Definition application.
SESP	Service Rule Definition (Service Penalty)	Define information on service penalty parameters used during the adjudication process on the Service Penalty dialog box, Service Rule Definition application.
SESR	Service Related Parameters (Weights)	Define the weights for each type of service in situations where service relationships exist on the Service grid, Indicative section, Service Related Parameters application.
SETR	Service Rule Definition	Define information that specifies tiering of co-pays, deductibles and coinsurance for the defined service rule on the Service Tier subsection, Service Rule Definition application.
SPAC	Supplemental Accident Benefits	Define first dollar benefits for charges related to an injury up to a specific dollar amount or for a specified number of days. Accident benefits paid are not subject to copays, coinsurance or deductibles.
SPCR	Supplemental Procedure Conversion Rules	Enter rules for supplemental procedure code conversion.
SPCT	Supplemental Procedure Conversion	Define additional rules within a Product to be used to translate a procedure code to a service code (as a supplement to the Service/Procedure

Acronym	Name	Description
		Conversion application).
SPHI	Proc/Prov Specialty Hierarchy	This application allows the user to create ordered lists of procedure codes/provider specialty combinations for servicing providers.
SRCR	Supplemental Revenue Code Conversion Rules	Enter rules for supplemental revenue code conversion.
SRCT	Supplemental Revenue Code Conversion	Establish additional ranges of revenue codes for a product component prefix to be translated to a type of service.
SSCD	SSO Waiver Criteria	Administer the criteria to substantiate a proposed surgery and waive the need for a second surgical opinion.
TPCT	Service/Procedure Conversion	Define how Facets converts procedure codes entered during claims processing to a service code.
UTED / AGUT	Dental Utilization Edits	Define utilization code parameters to ensure that providers are in compliance with the guidelines set forth within the benefit rules specific to each product being administered. The UTED prefix may be entered at the product level, the Class/Plan level or at the dental provider agreement level (AGUT). If an AGUT prefix is entered at the dental provider agreement level, it will override the UTED prefix entered on the Class/Plan Definition application and at the product level (UTED). If no Agreement Utilization Edit (AGUT) prefix is entered on the agreement, Facets will default to the UTED prefix entered on the Class/Plan Definition application, and if none is entered there, the prefix entered on the product will be used (UTED). During claims processing, Facets will review these utilization parameters and perform system edits to determine the status of a claim.
UTIP	Medical Utilization Edits by Procedure	Allows the user to establish dependencies based on a procedure code's relationship to other Service IDs. The purpose is to prevent the inappropriate utilization of medical services by establishing multiple 'if/then' scenarios that

Acronym	Name	Description
		could result in improper utilization of medical services. The user can define criteria based on diagnosis, provider and admit date, specify a time frame during which related services or procedures would have been performed in order for the edit to be applied and identify the action that will be invoked when a medical utilization edit applies.
UTSE	ITS Home Warning Message	Medical Utilization Edits by Service - Allows the user to establish dependencies based on a Service IDs relationship to other Service IDs. The purpose of this application is to prevent the inappropriate utilization of medical services by establishing multiple 'if/then scenarios that could result in improper utilization of medical services. The user can define criteria based on diagnosis, provider and admit date, specify a time frame during which related Services or Procedures would have been performed in order for the edit to be applied and identify the action that will be invoked when a medical utilization edit applies.
WIUD	ITS Home Warning Message	User Defined - Create unique warning messages that relates to ITS and associate each message with a subscriber, member, provider, procedure code, diagnosis code, employer group, subgroup, class Plan, service rule, agreement procedure definition, agreement exclusions and auto room type.
WIWM	ITS Home Warning Message	System - Identify system generated warning messages that are related to ITS and various events taking place during several Facets processing routines.
WMUD	User-Defined Warning Messages	Create unique warning messages and associate each message with a subscriber, member, provider, procedure code, diagnosis code, employer group, subgroup, class Plan, service rule, agreement procedure definition, agreement exclusions and auto room type.
WMWM	Warning Messages	Identify system generated warning messages

Acronym	Name	Description
		that are related to various events taking place during several Facets processing routines.
ZCIA	In Area Zip Codes	Define ZIP Code ranges considered as in area. The user may specify ZIP Code ranges considered as in area during claims or utilization management review processing. When the prefix that identifies a specific set of In Area ZIP Codes is linked to a Product, any claims or UM reviews received from a provider whose address does not fall within these ZIP Code ranges will be handled as out of area. Out of area claims or reviews may use a different set of variable components for adjudication.
ZPCD	ZIP Code Area Definition	Group first 3 positions of provider ZIP Codes into a specific geographic area for pricing purposes.
ZPRB	RBRVS ZIP Code Area	Group first 5 positions of provider ZIP Codes into a specific geographic area for pricing purposes.