Plan/Product and Components Configuration

Facets 5.0
Participant Guide

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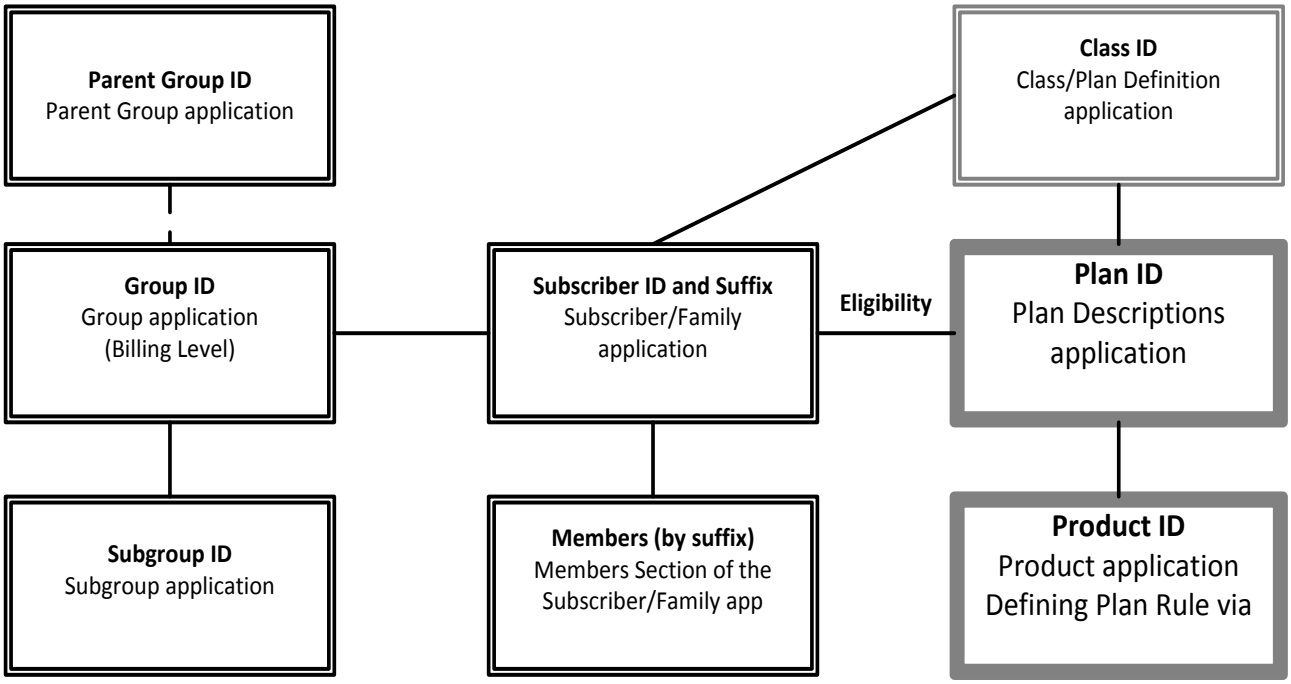
Table of Contents

Plan/Product

Plan/Product Structure



Plan

Group, Class, Plan, and Product relationships must be defined and their records loaded into Facets. This includes establishing eligibility links to the membership file.

The hierarchy of the Facets plan structure is:

1. Group
2. Class
3. Plan
4. Product

Each plan must be associated to a Product for each class. The Product application is the key to the plan structure. It holds the entire set of component prefixes that define benefits, limits, authorization requirements, and all other product rules.

Identify and establish the Group structure first. Groups must exist before creating a class of benefits for a group. After completing this, the user may tie the plan and the product to the class for each group.

Enter a Plan via the Plan Descriptions application, which is located in the Medical Plan application group. Do this prior to completing the class record, which is created in the Class/Plan Definition application.

The Class lists all plans available to a particular group. The number of classes that exist for each group will depend on the types of members in the group who are given different benefit options. For example, if the available benefits for active and retired employees of a group differ, then it will be appropriate to have separate classes for active and retired members.

Each subscriber/member must belong to a class of benefits. Eligibility also must exist. By going into the Subscriber/Member application group and opening the Subscriber/Family application, a user may select the **Class** section of the application and assign a Class ID to the subscriber. At this point, access the **Eligibility** section of the application to load the category, event, plan ID, and effective date information, giving the subscriber and related members eligibility to a plan listed in the class that was assigned to the subscriber.

Plan Descriptions Application

Use this application, found in the Medical Plan application group, to create, maintain, and view all Plan IDs in Facets. Create a Plan ID. After defined, associate the Plan ID with a Product ID using the Class/Plan Definition application.

Indicative Section

This section is an enterable grid that does not require a dialog box to add, edit, or delete information within the grid.

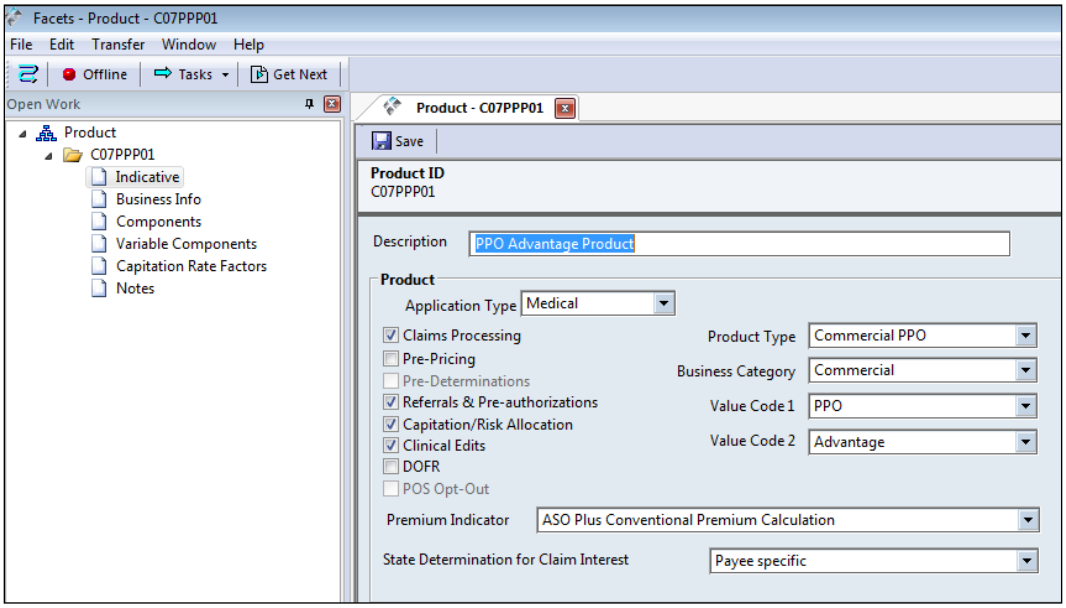
Field		Description
Fields denoted with an * are required.		
Plan	*	User-defined ID; may be up to 8-characters long.
Description	*	A free form field up to 70-characters; used to identify the marketing name for the plan (e.g. Platinum Premier Plan).

Product Application

The Product application is opened from the Medical Plan application group and is the key to the Facets plan structure. The product holds the entire set of component prefixes used to define benefits, limits, authorization requirements, and other rules defining the plan that will eventually be linked to the product.

Indicative Section

Use this section to name and define the type of product being created, as well as identify principal functions recognized by Facets when processing records or data associated with the product.



Field		Description
Fields denoted with an * are required.		
Product ID	*	User-defined 8-character code that identifies the product.
Description		Enter a user-defined description for the Product.
Application Type	*	This field identifies the 'type' of components (benefits/rules) to be added to the product. Types are: D = Dental, F – FSA, M = Medical, O = Other, R = Pharmacy and H = HSA. To further define "Other" Product Categories, refer to the Product Category Definition application in the Application Support

Field		Description
		application group.
Claims Processing		Used to indicate this product will include claims processing.
Pre-Pricing		Used to indicate the product includes medical claims pre-pricing. This option is not available for Dental products.
Pre-Determinations		Available only for Dental products for the function of pre-determining dental services.
Referrals & Pre-authorizations		Used to indicate a product will include the processing of Utilization Management service reviews and confinements. This option is not available for Dental products.
Capitation/Risk Alloc.		Identifies this product will be included in the capitation process.
Clinical Edits		Select this checkbox to reference clinical edits during claims and UM reviews. **Note**: This option is also available for Dental products. Clinical Edits functionality requires the EAAR and CECE components be added to the medical product, Components section and the DAER and DECE be added to the dental product, Components section.
DOFR		This option pertains to the Assigned Risk Module only. Select this indicator to enable the product for DOFR (Division of Financial Responsibility) processing. This check box is available when the selected Application Type is “Medical” or “Other”.
POS Opt-Out		**Note**: This option pertains to the Assigned Risk Module and POS processing only.
Product Type		Use this field to identify various forms of Medicare Risk and Commercial product types. If the primary coverage is Medicare Supplemental, “Not Applicable” must be selected
Business Category		User-defined category codes used for reporting purposes.
Value Code 1		User-defined code used to further describe the product. It may be used for reporting or to

Field		Description
		'group' similar products together.
Value Code 2		This user-defined code further describes the product and is filtered from Value Code 1. It is used for reporting or to 'group' similar products together. A value must first be entered in Value Code 1.
Premium Indicator		Used to select an indicator to include the product in the process of calculating premium rating and billing.
State Determination for Claim Interest		Select the value to determine which state to use to obtain interest rates and other related information. Valid values include: • G – Not applicable, Use General • P – Provider practice address state • S – Subscriber home address state • B – Payee specific (based on provider practice address for provider payments, subscriber home address for subscriber payments)

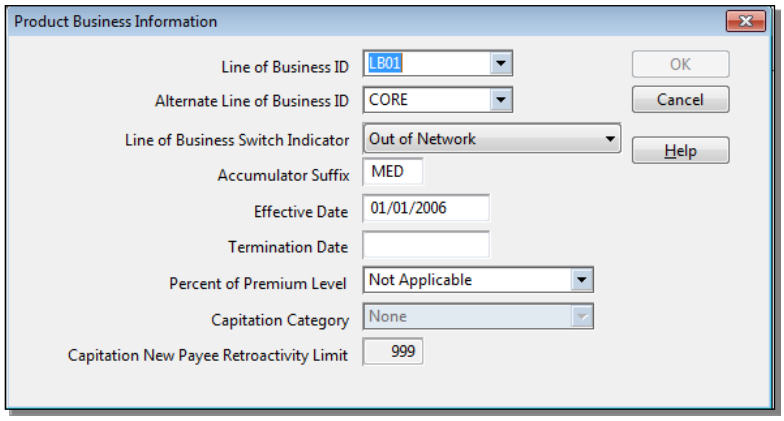
Business Info Section

This section allows the user to define the Line of Business to be used for a particular set of plan benefits.

Note: The **Business Info** section must be completed in order to process claims in Facets.

Product Business Info Section: Adding, Editing or Deleting

Step	Product Business Info Section: Adding, Editing or Deleting Procedures
1	To perform any function, first verify that the **Business Info** section displays. If it is not displayed, select the **F12** function key once, use the up-or-down arrow keys to select the **Business Info** section and press the **ENTER** key.
2	To add information, including effective and termination dates, select **Add** from the **Edit** menu (**Alt+E+A**) to display a dialog box.
3	To change existing information in this section, use the **TAB** and up and down arrow keys to select the date range (effective/termination) of information that should be changed. After a date is selected, select **Change** from the **Edit** menu (**Alt+E+H**) to display the **Product Business Information** dialog box.
4	To delete existing information in this section, use the **TAB** and up and down arrow keys to select the date range (effective/termination) of information to be deleted. After a date is selected, select **Delete** from the **Edit** menu (**Alt+E+D**) to verify the deletion by selecting **OK** from the displayed pop-up box.



Field		Description
Fields denoted with an * are required.		
Line of Business ID	*	This code identifies a specific product type (e.g. POS, HMO, Medicare, etc.) within a health plan. It associates separate business lines with specific benefit products, individual/combined claim checks and payments, as well as capitation adjustments.
Alternate Line of Business (LOB) ID		Select an alternate LOB ID for the product used during the claims adjudication process if a selection has been made in the Line of Business Switch Indicator field.
Line of Business Switch Indicator		Select the activity that would cause the claims adjudication process to switch from the primary line of business to an alternate line of business. This field is for informational purposes only. Facets does not read this value when determining whether to switch to a different variable component.
Accumulator Suffix		A four-character code assigned to the benefit product that relates member and family accumulators (limits, deductibles, COB and Incentive Dental) to a specific plan (e.g. medical, dental, etc.).
Effective/Termination Date		Enter the product effective and/or termination date in MM/DD/YY format.
Percent of Premium Level		Designates the level at which to aggregate billing data for capitation as a percentage of average member premium.
Capitation Category		A user-defined code available only when the **Percent of Premium Level** field is updated with "**Capitation Category**". The code designates the user-defined level to aggregate billing data for capitation as a percentage of average member premium.
Capitation New Payee Retroactivity Limit		**Note**: This option pertains to Capitation. This field offers the ability at a Plan level to set the number of months that a capitation batch will go back in time to recognize retroactivity when calculating the capitation

Field		Description
		payment for a new payee related to a capitated entity.

Keep in Mind...

When existing business information needs to be updated at the start of a specific date (e.g. new plan or calendar year), a new generation of the **Business Info** section of the product needs to be created. Use the **Termination Date** field to end the existing product business segment, and select **Add** from the **Edit** menu to create a new segment that begins with an effective date starting the following day after the termination date.

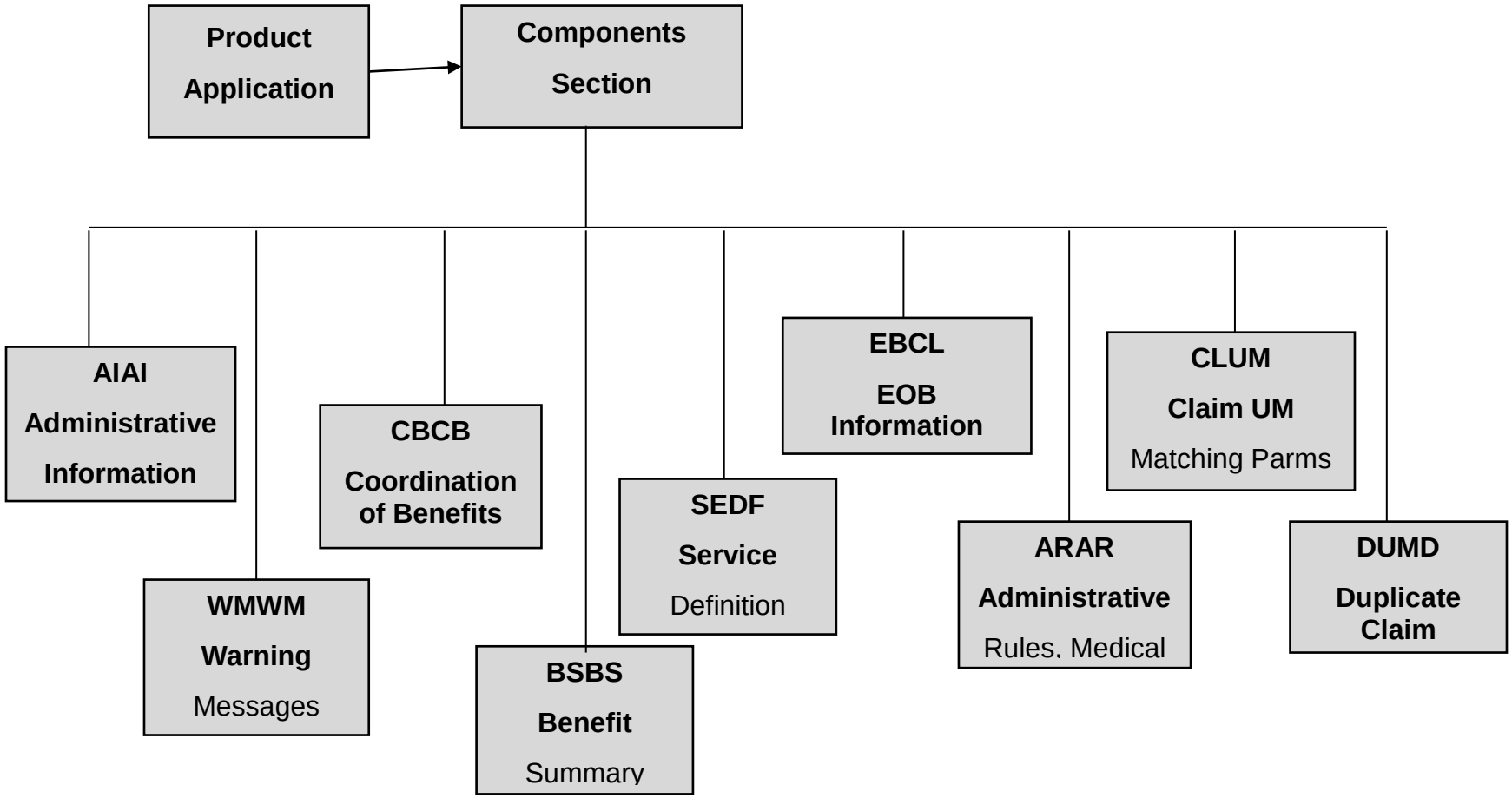
Note: Effective and termination dates cannot overlap.

The **Line of Business ID** and **Alternate Line of Business ID** dropdown menu fields display the same codes. Create the codes in the Line of Business application found in the Accounting application group.

The **Percent of Premium Level** field will only be available if the **Capitation/Risk Allocation** checkbox has been selected in the **Indicative** section of the product.

The codes displayed in the **Capitation Category** field are user-defined, created in the User-Defined Codes application in the Application Support application group under the Category of Plan Codes and under the Type, Capitation Category.

Partial Product Components Structure



Component Descriptions Application
(Application Support Application Group)

This application identifies and describes each of the different types of product components in the Facets database. All components are included in the Facets-supplied data. This table must be present in order to set-up a Product in Facets.

Note: TriZetto must be contacted before modifying or adding to this application, as Facets logic will not recognize any new components added.

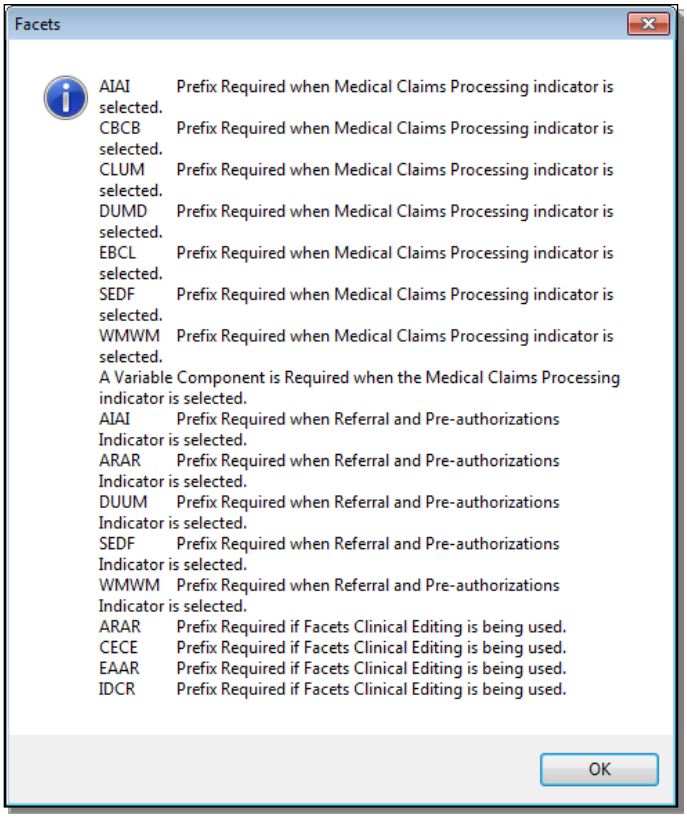
Product Application

Components Section

This section lists all applications (a.k.a. component types) and the user-defined prefixes and that identify them. These components are the links to the rules and benefits used for this product. Facets must review these components when determining benefits for a member's product during claims and/or UM review processing. In this section, information is maintained in an enterable grid, which does not require a dialog box for adding or updating the information.

Field		Description
Fields denoted with an * are required.		
Type	*	Select a component type from the drop-down field. Components are used to determine benefits (e.g. CBCB for COB Rules). TriZetto supplies the component types in the Component Descriptions application (Application Support application group).
Prefix	*	Select a prefix from the drop-down field. **Note**: The prefix had to be previously created from the application that is identified in the **Type** field.
Effective / Termination Date	*	Enter the component effective and/or termination date in the format of MM/DD/YY. The termination date is not required.

Note: Certain product components are required by Facets. The information entered in the Indicative section of the product will determine what components will be required. If all required components are not entered, a pop-up box will appear, as shown below.



The components in this pop-up box are required for a product that will process claims, UM reviews, and clinical edits. They are shown in the pop-up box because they were not added to the **Components** section before the user attempted to save the product.

Keep in Mind...

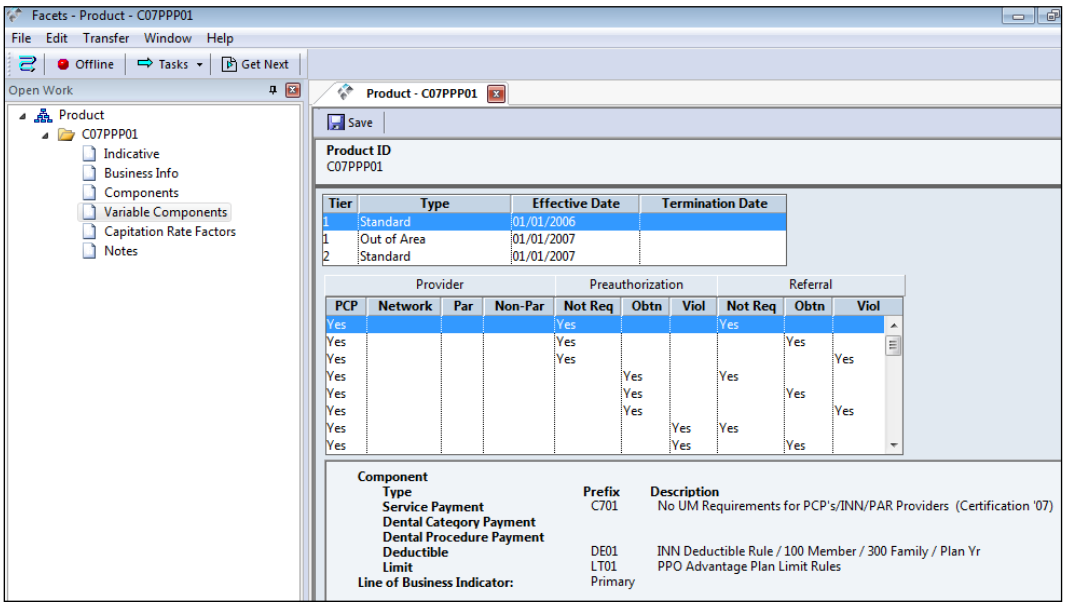
Component Types are TriZetto supplied. Component Prefixes must first be created and saved from applications listed in the Medical Plan application group. For example, an AIAI component type prefix is created using the Administrative Information application. The component Prefix Type, NSRS (OON NetworXPricer Contract Terms ID) is used specifically for NetworX out of network pricing. The **NSRS ID** needs to equal the **Agreement ID**, which is created in the Agreement Configurator application. This type is enabled to act as a default for out of network situations in determining a price within NetworXPricer. The user will need to configure the **Agreement ID** to be only four characters long, which is the length allowed for a Benefit Component Prefix when it is utilized for default pricing. If the user does not configure a Benefit Component type of NSRS, the system will attempt to invoke Facets pricing when pricing is identified on the product (through the default Service Definition/SEDF).

Note: The only way to see more than one of the same component type in the Components section is to terminate the first entry by entering a Termination date.

Note: Refer to the NetworX Pricer user guide for more information on NSRS.

Variable Components Section

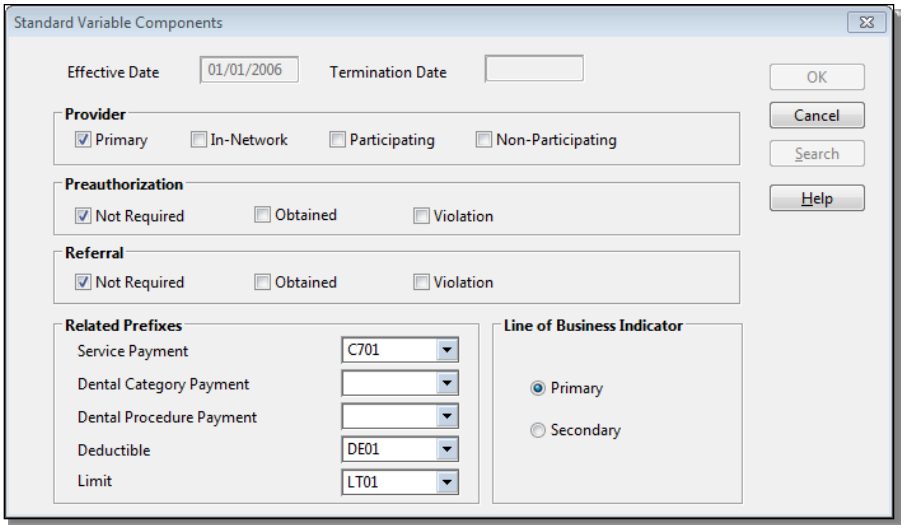
This section of a product stores three component types: Service Payment, Deductibles, and Limits. During claims processing, Facets will select one of these scenarios (rows) to determine how to pay benefits for each service on the claim using the identified Service Payment, Deductible, and Limit prefixes.



Variable Components Section Maintenance

Step	Variable Components Section Maintenance Procedures
1	Select **Add**…**Section** from the **Edit** menu (**Alt+E+A+S**) to display the **Add** dialog box. **Note:** use **Edit…Change…Section** (**Alt+E+H+S**) to make changes
2	Enter the **Effective** date (and **Termination** date, as necessary).
3	Enter the **Type** and **Tier** fields. Select **OK** to apply the entry.
4	Select **Add**…**Subsection** from the **Edit** menu (**Alt+E+A+B**) to display a **Variable Components** dialog box (shown below). The actual name of the dialog box will be dependent on the selection made in the **Type** field. This dialog box will be used to enter the various 36-different situations a service may be rendered and the appropriate Service Payment, Deductible, and Limit prefixes that should be used for each situation.
6	The **TAB** key may be used to move from field-to-field.
7	Use the **SPACEBAR** to select and deselect entries in the check

	boxes and fields.



Step	Variable Components Section Maintenance Procedures (continued)
8	To change existing information in the **Variable Components** section screen, use the **TAB** and the **Alt + up-and-down arrow** keys to select a section tab.
9	Use the **up-and-down arrow keys** to select either the date-range row or the scenario row that needs to be changed.
10	Select **Change**…**Section/Subsection** from the **Edit** menu (**Alt+E+H+S/B**); choose **Section** to edit the **Effective** and **Termination** dates as well as **Type** and **Tier** information, or choose **Subsection** to edit the row selected in the lower grid. **Note:** use **Edit…Delete…Section/Subsection** (**Alt+E+D+S/B**) to delete data (based on security permissions).

Field		Description
Fields denoted with an * are required.		
Effective/Terminate Date	*	The date-range in which the listed situation and variable components are valid for the indicated Type.
Provider checkboxes	*	Identifies the type of provider who rendered the service. Choices are Primary (PCP), In-Network, Participating, and Non-Participating.
Preauthorization	*	Identifies the preauthorization status of the rendered service. Choices are Not Required,

Field		Description
checkboxes		Obtained (it was required), and Violation (it was required and not obtained).
Referral checkboxes	*	Identifies the referral status of the rendered service. Choices are: Not Required, Obtained (it was required), and Violation (it was required and not obtained).
Related Prefixes	*	Five drop-down menu fields used to indicate the variable components used when a service is rendered according to the selected check boxes for Provider, Preauthorization, and Referral. The prefixes shown in all five fields must first be created and saved in their respective applications before they can be displayed in the field. The Service Payment component will relate to Medical and Other product types, while the Dental Category Payment and Dental Procedure Payment will relate to Dental products. Deductible and Limit components may be used for both product types including Other.
Line of Business Indicator	*	Identifies which Line of Business should be referenced when a service is rendered according to the selected check boxes for Provider, Preauthorization, and Referral. “Secondary” relates to the Alternate Line of Business ID indicated in the Business Info section of the product.

Keep in Mind...

In order to use any of the “Types” that indicate “out of area,” zip code ranges must be established using the In Area Zip Codes (ZCIA) application found in the Medical Plan application group.

When a claim or UM review is processed or pre-priced, Facets uses the servicing provider’s primary address zip code to determine “in area” or “out of area” components.

Note: The **Edit** menu bar offers the additional options of **Insert**, **Validation**, and **Add Generation**. Insert is to used add an additional scenario row between existing rows in the sections grid. Validation is used to display a **Variable Components Validation** dialog box used to verify the 36-different scenarios that may be set-up for a given “Type”. Add Generation is used to duplicate existing scenario rows and related prefixes for specific “Type”.

Keep in Mind...

Facets requires that an Effective date entered via dialog box. The date will be used to identify when the new or duplicate Type should become active and when the old Type should be terminated. Once the duplicate Type is created, a user may then make the necessary changes to the scenario rows and related prefixes.

A Variable Component row cannot have overlapping Effective and Termination dates between different generations. If this is the case when creating a generation via the Add or Add Generation options, Facets will display an Error message stating overlapping dates exist.

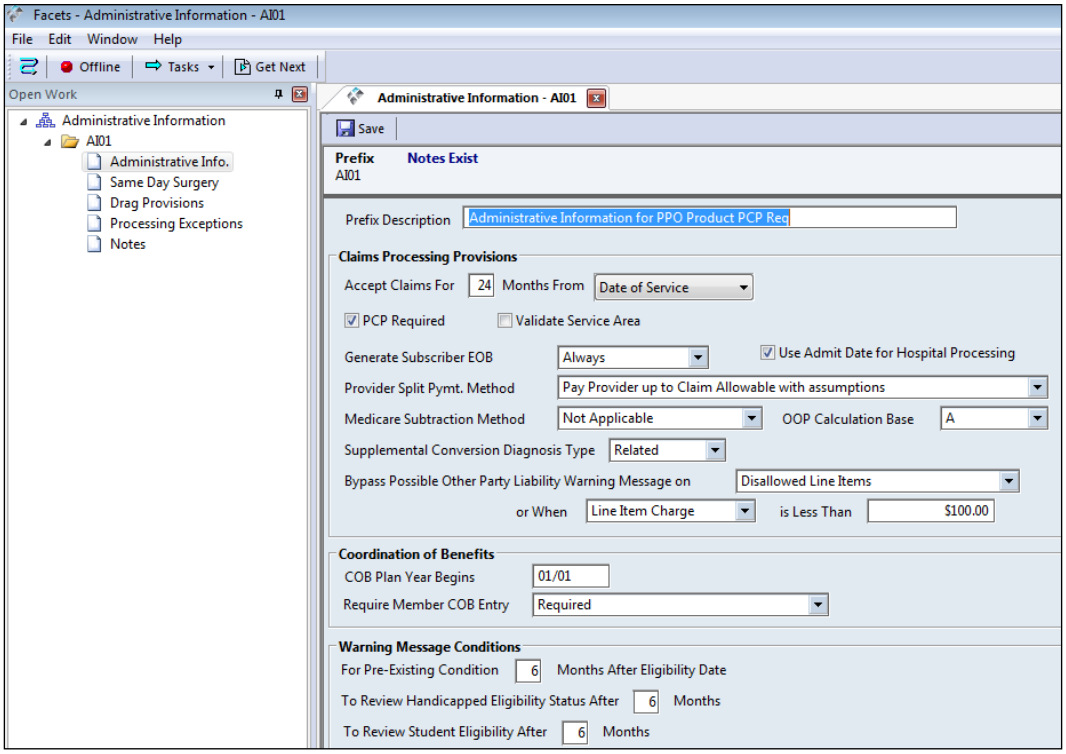
Administrative Product Components

Administrative Information Application (AIAI)

The Administrative Information (component type = AIAI) application allows a user to define high-level plan rules concerning plan set-up, claims processing, utilization management, and warning messages. The rules identified on the AIAI are applied to a product by attaching the prefix of the AIAI to the Components section of the product.

Administrative Info. Section

This section defines administrative requirements that will be referenced during UM and claims processing for plans linked to a product that lists the same AIAI prefix shown in the Record Information area (top) of this application screen. The user may define claims processing provisions by setting the acceptance period for the months from the date of service or calendar year to allow claims to process. Users may also set warning messages for pre-existing conditions, temporary handicapped status, and student eligibility for claims and UM reviews. The Prospective UM application uses the **PCP Required** field and warning message for **Pre-Existing Condition** field to edit referrals and pre-authorizations.



Field		Description
Fields denoted with an * are required.		
Prefix Description		This is a user-defined free-form field that describes the AIAI component record being created.
Claims Processing Provisions: Accept Claims For	*	The entry made here will be used for claims received from providers who have no provider agreement or from providers whose agreements do not specify a number of claim accept months. **Note**: For all other providers, the "Claim-Accept Months" entered on the provider's medical agreement will override the entry made here.
Claims Processing Provisions: Months From	*	Use this field to determine if the 'claim acceptance months' entry (from the AIAI or Provider Agreement) starts from the 'date of service' or from the 'end of calendar year'. The default is "Date of Service". Example: Claim acceptance months = 24, and the claim has a date of service of August 2, 1998. The claim would be accepted until August 2, 2000 if the option were set to Date of Service, and until December 31, 2000 if the option was set to End of Calendar Year. If a claim is received in the year 2001, the claim will deny with a disallow reason of TF0, timely filing limit reached.
Claims Processing Provisions: PCP Required		This field identifies if a PCP is utilized for the plan that is linked to a product. When this option is checked, and a member has not selected a Primary Care Physician, Facets will generate a warning message in the Subscriber/Family and Enrollment applications to notify the user that a PCP is required according to plan requirements. When this option is not checked and the member has selected a PCP, Facets will ignore the PCP relationship. The product variable components used during claims

Field		Description
		processing and utilization management will be the appropriate non-PCP scenario rows.
Validate Service Area		This option pertains to Service Area / the Assigned Risk Module only.
Claims Processing Provisions: Generate Subscriber EOB		This field contains the condition under which Facets will generate an Explanation of Benefits (EOB) for the subscriber. When a claim is processed through the payment batch, Facets will generate EOBs (notification of provider payment rows) based on the indicators selected.
Claims Processing Provisions: Use Admit Date for Hospital Processing		Facets will automatically populate a claim-level override called “Benefit Calculation Date” with the admission date, as well as associate it with the explanation code, PBA (Benefits Based on Admission Date). The entire claim will then be processed based on this override date, which may be changed. **Note**: When this field is enabled, Facets will apply it when making changes to Room Types on a claim. If a second room type is used for part of the admission, the pricing used will be the amount in effect on the admission date, even if the price changed during the confinement.
Claims Processing Provisions: Provider Split Pymt. Method		This field indicates the method used by Facets to perform partial payment calculation when the member has already reimbursed the provider for a portion or all of the charges. Split payment amounts are determined after any COB calculations and are only applied when payment is assigned to the provider.
Claims Processing Provisions: Medicare Subtraction Method		Select the Medicare Subtraction Method for Medicare claims. **Note**: Normally, COB information is administered through COB Rules, but they do not apply when Facets uses this method. In those cases, each claim is calculated on a claim-by-claim basis, so COB member-level accumulators are not affected.

Field		Description
		Note: When using the "Other Carrier Allowable" as the Medicare Subtraction Method, the user must also establish the maximum values in the Amount and Counter fields (9,999,999.99 and 999, respectively) on the Indicative section of the Service Rule Definition application for the corresponding Service Tier.
Claims Processing Provisions: OOP Calculation Base	*	When calculating coinsurance, deductible and co-payment, either use the allowable price or use the lesser of the billed charges or pricing allowable, including or excluding external prices. This is only functional if "Pay Profile Amount" is enabled on the Service Pricing application. If this is not the case, Facets defaults to use "A", the allowable price, during claims adjudication. Valid values include: A – Use Pricing Allowable, E – Lesser of Billed Charges or Pricing Allowable, including external prices, and L – Lesser of Billed Charges or Pricing Allowable, excluding external prices.
Claims Processing Provisions: Supplemental Conversion Diagnosis Type	*	This field allows users to determine whether the diagnosis ranges used during the supplemental conversion process are based on the diagnosis submitted on the claim or on the related diagnosis. Options include: • R = Related (e.g.: submitted 250; Facets will look at 250, 2501,2505, etc.). This is the default. • S = Submitted (e.g.: submitted 250; Facets only looks for 250).
Claims Processing Provisions: Bypass Possible Other Party Liability Warning Message on __ or When __ is Less Than __		Facets allows the user to bypass the generation of an Other Party Liability Potential warning message in situations where the line item is being denied or is capitated, or when the charges or allowable fall below a stated dollar amount threshold. Users have the ability to indicate the conditions under which to suppress generation of the Other Party Liability (OPL) warning message. **Note**: This bypass applies only to the generation of

Field		Description
		warning message “0090” and claim pending caused by this warning. Functionality linked to “Other Party Liability” and “Continuation” entries on the member’s Conditional Eligibility screen (found in the member’s Subscriber/Family application) will remain in effect.
Coordination of Benefits: COB Plan Year Begins	*	Facets allows users to establish a COB Plan Year Begins Date that differs from the (‘standard’) Plan Year Begins Date. For example, users may establish a COB Plan Year Begins Date of January 1 to satisfy requirements for calendar year accrual of COB savings. Enter the month and day the COB plan year begins for products containing this AIAI prefix. Facets uses this date when the **Accumulation Method** field selection on the COB Rules application is “Per Claim savings, Accumulators updated” or “Plan Year accumulation of savings.”
Coordination of Benefits: Require Member COB Entry		If an indicator other than ‘blank’ (“Required”) is selected here, Facets adjudicates the claim including the COB routine, based on the COB Rule Type (indicated in the COB Rules application) that matches the entry in this field. For example, if this field contains a value of “C – Not Required, Default to Commercial Medical,” and the claim contains ‘other carrier paid’ data, Facets applies the rules from the product’s COB Rules application for “Type C – Commercial Medical” to adjudicate the claim. If a match cannot be found, the existing error message, “COB Rule Prefix Not Found on Product Component Table” displays.
Coordination of Benefits: Require Member COB Entry (continued)		If a claim is received for a member with no COB information on file with a Carrier Type that does not match the entry in this field, the default logic will occur, and the Carrier Type on the claim will change to match the value entered in this field.
Warning Message		Enter the number of months after the

Field		Description
Conditions: For Pre-Existing Condition _ Months After Eligibility Date		enrollment date when the member is subject to pre-existing condition benefit exclusions. Claims processed during this time will be flagged with a warning message reminding users that a pre-existing condition may exist. Pre-existing conditions are attached to the member in the Subscriber/Family and Enrollment applications. Limits (Limit Rules application) may be established for claims submitted related to pre-existing conditions.
Warning Message Conditions: To Review Handicapped Eligibility Status After _ Months		Enter the number of months after review of the member's handicap status that a warning message will appear in claims processing. This will alert the user that handicapped eligibility should be reviewed again. Members classified as, 'permanently handicapped' will be eligible beyond their termination dates. Handicapped eligibility is entered in the Members section of the Subscriber/Family and Enrollment applications.
Warning Message Conditions: To Review Student Eligibility After _ Months		Enter the number of months after a review of the member's student status that a warning message will appear in claims processing to alert the user that student eligibility status should be reviewed again. Student eligibility status is attached to the member in the Subscriber/Family and Enrollment applications.

Same Day Surgery Section

Same Day Surgery Guideline fields are used to automatically reduce benefits for multiple same day surgeries performed by the same provider. Services are identified as "Surgery" or "Assistant Surgery" in the Service ID Descriptions application. The user may also select coinsurance levels and the method (billable or allowable) used to determine which surgery or assistant surgery, when performed on the same day by the same provider, will be considered as primary, secondary, tertiary, or other. Same Day Surgery Guidelines only apply to surgeries unaffected by clinical editing. A warning message displays when same day surgery is detected in history.

Field		Description
Fields denoted with an * are required.		
Prefix Description		Carried over from the Administrative Info. section.
Action		Select the method used to determine which surgery will be considered as primary, secondary, tertiary, or other. Tiering occurs after clinical edits have been applied. If more than one procedure is billed or allowed at the same amount, the first line item will be considered primary. When NetworX pricing is used, the warning message "Same Day Surgeries Detected in History" or "Same Day Assistant Surgeries Detected in History" will display during claims processing. This option allows users to receive 'multiple same day surgery' warning messages no matter which pricing functionality they are using.
Action (continued)		Valid values include: • A – Primacy based on Allowable: When Facets pricing is used, all benefit calculations will occur and tiering will take place prior to applying deductibles, copays, and coinsurance. When NetworX pricing is used, the percentages are ignored and the warning message displays during claims processing. • B - Primacy based on Billed charges: When Facets pricing is used, tiering takes place immediately following clinical editing. When NetworX pricing is used, the percentages

Field		Description
		are ignored and the warning message displays during claims processing. • W – Warn History Only: When NetworX pricing is used, the warning message displays during claims processing. **Note**: This value is only used for NetworX pricing. • Blank – None.
Assistant Surgeon		Select the check box if the same day surgery guidelines should be applied to assistant surgeons as well as surgeons.
Coinsurance Levels: Secondary, Tertiary, Other		Enter the percentage amount that will be applied to the billable or allowable amount for the surgery or assistant surgery that has been tiered as the secondary, tertiary or beyond the tertiary procedure if more than one surgical procedure occurs. The primary surgery is always considered at 100%.
Explanation		Select a code for the explanation that will display during claims processing when a charge is reduced due to same day surgery guidelines.

Drag Provisions Section

This section allows a user to set criteria to hold the production of a check for a provider and/or subscriber for an established time period. The section is only used when the product pertains to claims processing.

TAB to move the cursor from one field to another. Use the **SPACEBAR** to select fields represented by radio buttons. Entries in drop-down fields can be typed in, or a selection can be made using the **Alt + up** or **down arrow** keys.

Note: When certain fields are selected, other fields may be unavailable for data entry.

Field		Description
Fields denoted with an * are required.		
Prefix Description		Carries over from the Administrative Info. section.
Payment Frequency:		Select the radio button that indicates the frequency of when a check should be produced for payment. • No Drag - No drag provisions are established; all fields are unavailable. • Once each week on - Checks are produced one day out of the week. Use the dropdown field to select the day of the week. • Monthly on - Checks are produces on specific dates during a month. The drop-down fields are used to indicate up to three dates in a month. • Month Following on - Checks are produced the following month on specific dates. The drop-down fields are used to indicate up to three dates in the following month. For example: the dates 10, 20, and 31 are entered, and the current month is January. Facets would produce checks for claims processed between 12/1 and 12/10 on 1/10, for claims processed between 12/11 and 12/20 on 1/20, and for claims processed on between 12/21 and 12/31 on 1/31. • Days from Base Date - Select the radio button that indicates the frequency of when a check should be produced for payment.
Payment Frequency		Checks are produced a specified number of

Field		Description
(continued)		days from the indicated **Base Date** on the screen. Use the field to the right of this selection to enter the number of days.
Base Date		This field indicates whether the claim received date or claim accepted (processed and sent to batch run) date would be used as the starting point in the calculation of the payment drag period. **Note**: The field is only available when the "Days from Base Date" Payment Frequency has been selected.
Apply Drag to		Indicates whose checks (subscriber and/or provider) will have the drag applied to them. If a payment drag frequency is defined, the user must make a selection in this field.

Keep in Mind...

If a payment drag is indicated on a provider's agreement, it overrides the payment drag that is entered on the AIAI product component.

Benefit Summary Descriptions Application
(Application Support Application Group)

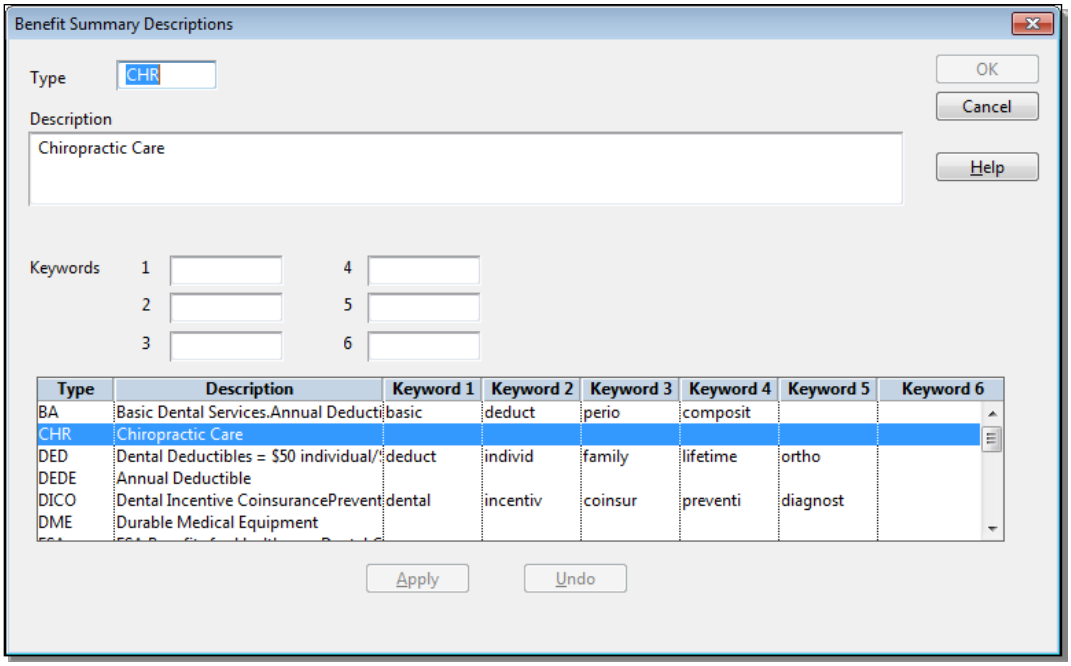
This application stores the Benefit Summary Type & Description and Benefit Details Type & Description. Users may enter up to six keywords on each Benefit Summary row used in filtering Benefit Summary data. Benefit descriptions can be up to 255 characters. Through the use of keywords for each summary row, benefit summary data can be filtered in the following applications: Claims Inquiry, Claims Processing, Customer Service, Prospective UM, and UM Inquiry.

Benefit Summary Section

This section displays all the benefit Types and Descriptions entered in the **Benefit Summary Descriptions** dialog box (shown below).

Add or Change Benefit Summary Info

Step	Add or Change Benefit Summary Descriptions Procedures
1	From the **Benefit Summary** section, select **Add** or **Change** from the **Edit** menu (**Alt+E+A/H**) to access the **Benefit Summary Descriptions**. Double-clicking on an existing row also displays the dialog box. If adding a new benefit type, a blank **Benefit Summary Descriptions** dialog box displays. If editing an existing benefit type, the dialog box displays the current information.
2	Complete the fields and choose **Apply** to add the new row to the grid.
3	Choose Undo to remove a row entered in this session.
4	Choose **OK** to close this dialog box.



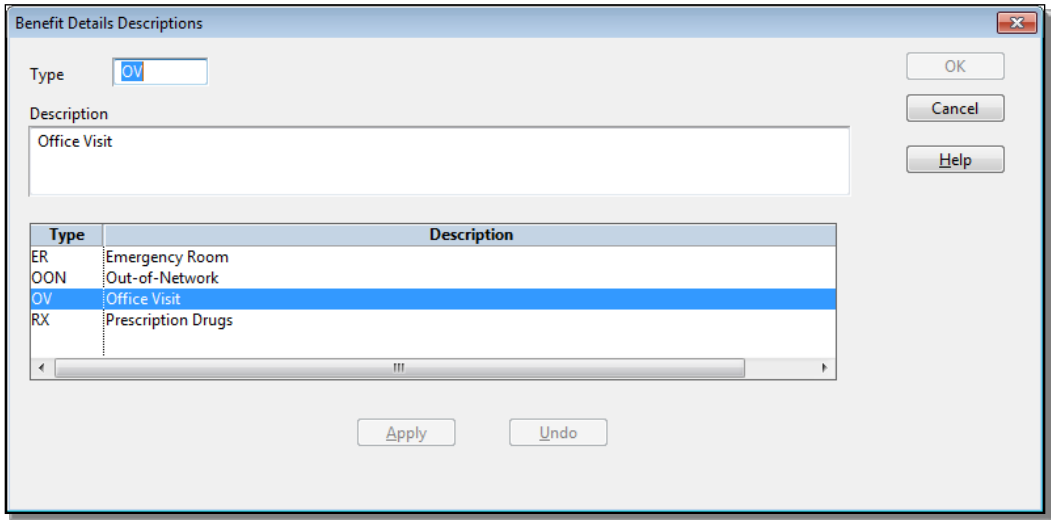
Field		Description
Fields denoted with an * are required.		
Type	*	Enter the 4-character ID for the benefit type.
Description	*	Enter the description for the benefit summary row.
Keywords 1-6		Enter the keyword used for filtering the benefit summary rows. **Note**: If upper-case is entered, Facets converts the letters/characters to lower-case.

Benefit Details Section

This section displays the type and description of the specific benefit row highlighted. This information is entered in the **Benefit Details Descriptions** dialog box.

Add or Change Benefit Details:

Step	Add or Change Benefit Details Procedures
1	Select **Add/Change** from the **Edit** menu (**Alt+E+A/H**) to access the **Benefit Details Descriptions** dialog box. If adding a new benefit type, a blank **Benefit Details Descriptions** dialog box displays. If editing an existing benefit type, the dialog box displays with the current information.
2	Complete the fields and choose **Apply** to add the new row to the grid.
3	Choose **Undo** to remove a row entered in this session.
4	Choose **OK** to close this dialog box.



Field		Description
Fields denoted with an * are required.		
Type	*	Up to 4 alphanumeric characters. Enter the 4-character ID for the benefit details type.
Description	*	Up to 255 alphanumeric characters. Enter the description for the benefit details row.

Benefit Summary Application (BSBS)

The Benefit Summary record is a product component that allows a user to define benefit summary information for different types of plan coverage. The information entered in this application is informational only and can be used for reporting purposes, as well as a reference by a user when processing claims, UM reviews and customer service episodes. The prefix created from this record must be attached to the **Components** section of a product in order to use and view the information stored in the application.

Benefit Summary Info Section

This section stores and maintains descriptions for user-defined benefit types. For each benefit, type entered in the top grid, a corresponding description displays in the text-out area below the grid. This section is also used to define the prefix for the record, which eventually will be added to a product. The user may refer to this information from Claims, UM, and Customer Service by pressing **F6** or choosing **Benefit Summary** from the **View** menu; the **Benefit Summary** dialog box displays.

Benefit Details Section

This section displays the full 255-character description and corresponding data. It is also used to enter and identify user-defined information for each benefit, such as the co-pay, deductible, coinsurance, and limit amounts associated with each service offered by a plan. The information in this section is entered and maintained manually. Once entered, the same information shown here can also appear on member ID cards.

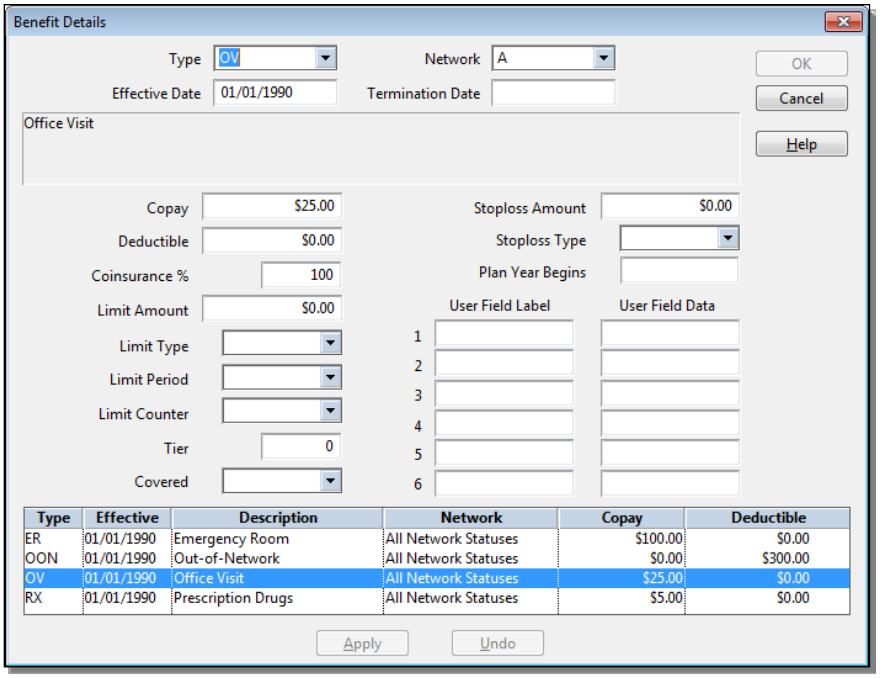
Keep in Mind...

If benefits are associated with a product change, the information stored in the Benefit Summary application must be changed manually.

When changes are made to the Service Payment, Dental Category Payment, Limit Rules and/or Deductible Rules applications, and a reminder to update, the Benefit Summary application may appear in the Record Information area (top) of those applications. In order to get this message to display, a system parameter needs to be set-up on the SA (System Administration) side of Facets first. The message, “Benefit Summary Update Required?” appears in those above stated applications as a reminder message when the system parameter is enabled.

Benefit Summary Dialog Box:

The **Benefit Summary** dialog box is available from the **View** menu (select **F6** to open/close this dialog box) in the following applications: Claims Inquiry, Claims Inquiry+ITS, Prospective UM, UM Inquiry, Case Management, UM Logging, Appeals, Health & Care Assessment, Group, Customer Service, and all Claims applications.



Viewing the Benefit Summary Dialog Box

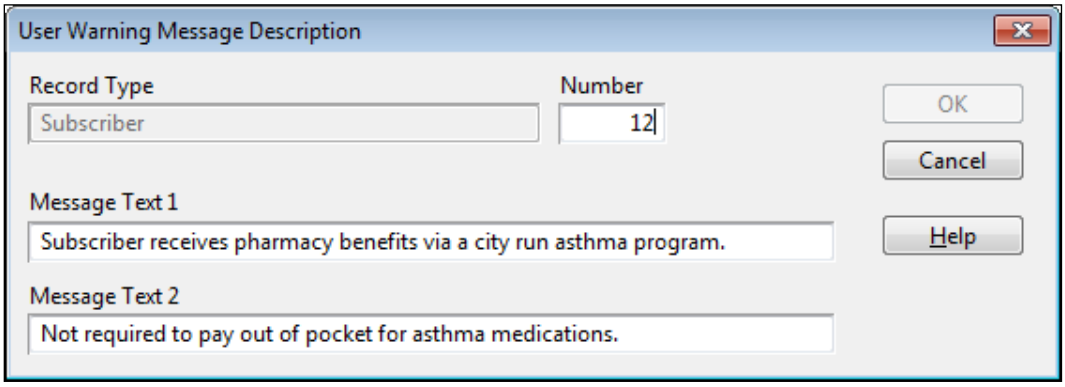
Step	Add or Change Benefit Details Procedures
1	Select an option in the **Prefix** field (based on timeframe) to view that prefix.
2	Enter a value in the **Type by Keyword** field and choose the **Filter** button to view those **Benefit Summary Description** rows that match the keyword input. Users can enter several characters followed by the % wildcard to have Facets return all rows that have the character sequence entered.
3	Enter a value in the **Details by Date** field and choose the **Filter** button to view the **Benefit Details** rows in effect as of the date entered.
4	To bring back all rows once a filtered entry has been made, the user must change the values in the **Type by Keyword** and **Details by Date** fields back to ‘blank’ and choose Filter again.

User Warning Message Descriptions Application
(Application Support Application Group)

Use this application to add, change, or delete non-system generated user warning message descriptions for the corresponding database entry (procedure code, diagnosis code, etc.). They can also be altered in the User Warning Messages application (WMUD) and linked to a product. These messages display during on-line processing in Claims, Case Management, UM, and Customer Service (no message will display if WMUD is not linked to the product). If the user's security level requires it, a claim will be pended for review.

Indicative Section

This section displays the user warning message descriptions for each **Record Type**, such as Subscriber, Provider, Procedure, or Diagnosis Code.



Within each record type, each user-warning message will be assigned a user-defined sequence number and message text that may include up to 2-messages (each message may be up to 70-characters in length).

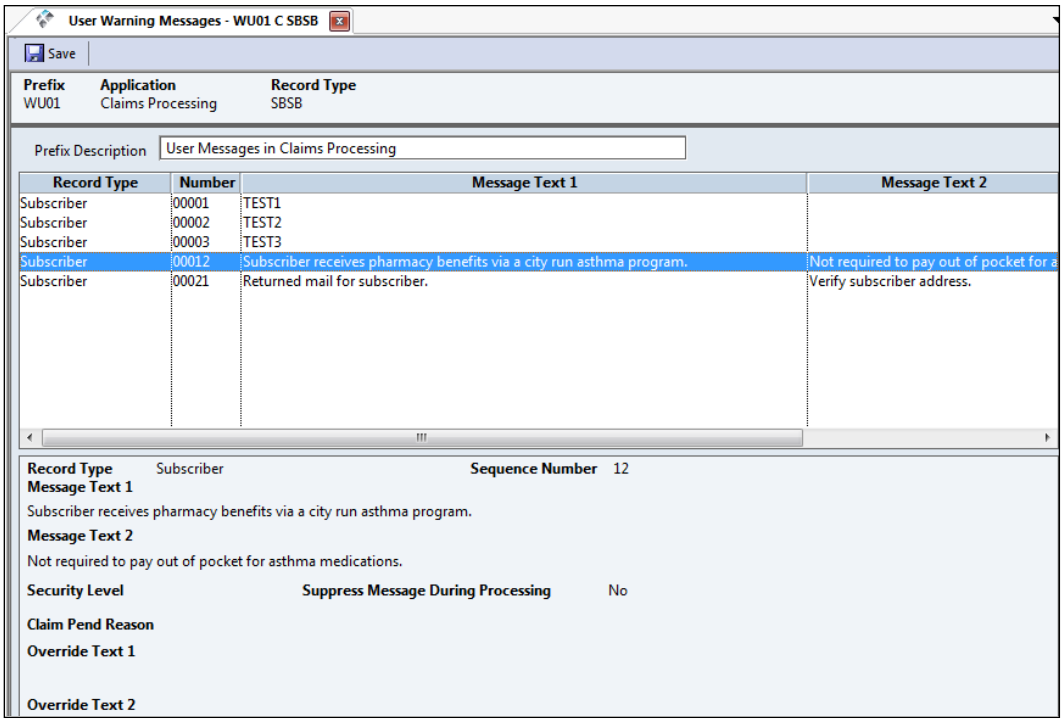
Note: For each Record Type, the user may also determine which messages will be applied to the different applications (**C** - Claims, **M** – Case Management, **S** - Customer Service, and/or **U** – Utilization Management). This is done by linking the messages to the WMUD (User warning Messages application) after they are first created here in this application.

Adding a User Warning Message Description:

Step	Adding User Warning Message Descriptions
1	Select **New**/**Open** from the **File** menu (**Ctrl+N** / **Ctrl+O**).
2	Select a **Record Type i.e. PRPR**.
3	Choose **OK**.
4	Select **Add** from the **Edit** menu (**Alt+E+A**).
5	Complete the **User Warning Message Description** dialog box. Select **OK**. See field descriptions below.
6	Select **Save** from the **File** menu (**Ctrl+S**), or choose the **Save** button.

Field		Description
Fields denoted with an * are required.		
Record Type	*	System-generated. Facets displays the record type the user selected in the **New** or **Open** dialog box, which links this record type to a user-warning message.
Number	*	Enter a number for the user-defined warning message. Numbers should be applied to Warning Messages in a sequential order and must be unique for each **Record Type**.
Message Text 1	*	Enter a text to appear when this 'User Warning Message' displays during on-line processing. If the message exceeds 70-characters, enter an additional text for this message in the **Message Text 2** field.
Message Text 2		Enter the text to appear when this user-warning message displays during on-line processing. This text follows any message entered in the **Message Text 1** field, but will not display if a text is not entered in the **Message Text 1** field.

After a user warning message description is set-up and saved in the User Warning Message Descriptions application, it may then be linked to the User Warning Messages application (WMUD), which is attached to the Product, **Components** section (the User Warning Messages application is found in the Medical Plan application group).



A particular warning message may then be linked to a particular record (e.g.: Provider, Subscriber, Group, etc.) and will appear during on-line processing.

Adding a User Warning Message:

Step	Adding User Warning Message Procedures
1	From the Application Support application group, select the User Warning Message Descriptions application.
2	Create/open the User Warning Message Descriptions application.
3	Add a new User Warning Message and Save.
4	From the Medical Plan Application group, select the User Warning Messages application.
5	Open/Create the User Warning Messages application.
6	Add User Warning Messages that were entered in step 3 and Save.
7	Open the Product application.
8	Add the WMUD component to the Product component section.
9	Add the User Warning Message to the appropriate application (e.g. add warning message to Subscriber).

User Warning Messages Application (WMUD)

The User Warning Messages application (found in the Medical Plan application group) allows users to associate User Warning Message Descriptions with one or more products. In the User Warning Messages application, users may create unique warning messages and associate each message with a subscriber, member, group, provider, procedure code, or diagnosis code, for example.

This application also allows users to:

- Determine whether or not to suppress the message from generating within the processing application from one product to the next
- Set the message to a level of security that is either above or below the level of security of each user
- Identify the appropriate Claim Pend Reason code that should be associated with this warning message during claims processing

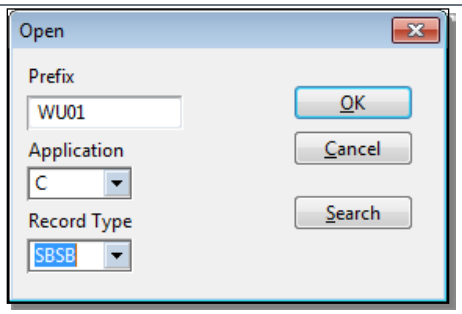
After a user warning message description is set-up and saved in the User Warning Message Descriptions application (shown below), it may then be linked to the User Warning Messages application (WMUD), which is attached to the Product, **Components** section.

Indicative Section

This section of the User Warning Messages application (found in the Medical Plan application group) displays the record type, sequence number, and message text for all user-warning messages associated with a product. A particular warning message may then be linked to a particular record (e.g.: provider, subscriber, group, etc.) and will appear during on-line processing.

Adding a User Warning Message:

Step	Adding User Warning Message Procedures
1	Information is entered, reviewed, or modified in this section by either selecting **New** or **Open** from the **File** menu (**Ctrl+N** or **Ctrl+O**).



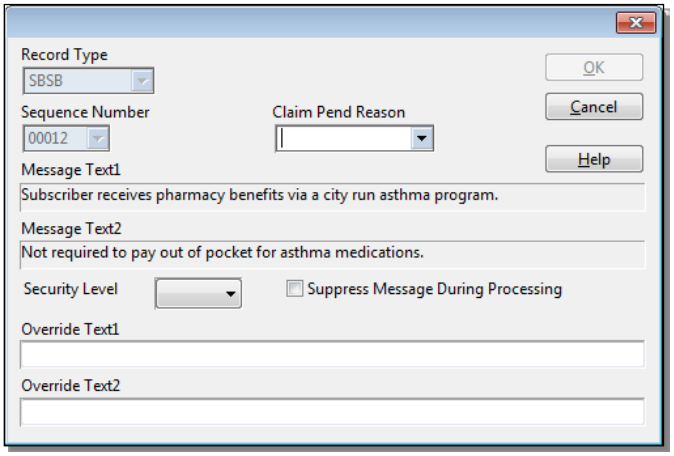
The **Application** field indicates which processing application the warning message will be seen.

Record Type field will determine what user-defined warning messages will be available to add to this application.

When the messages were created in the User Warning Message Descriptions application in the Application Support application group, they were defined by Record Type and Sequence number.

Adding a User Warning Message:

Step	Adding User Warning Message Procedures (continued)
2	To link a user-defined warning message to a security level and a pend reason, select the **Edit**…**Add** menu option to access the dialog box, or double-click on a user-defined warning message row that has already been created.



Field		Description
Fields denoted with an * are required.		
Record Type	*	The record type or file type associated with user-defined warning messages that are available from the Sequence Number drop-down field. New or Open from the File menu (Ctrl+N/O) updates this field.
Sequence Number	*	A 5-digit unique number assigned to each user-defined warning message. This number is created in the User Warning Message Descriptions application, Application Support application group.

Field		Description
Claim Pend Reason		Select a user-defined reason for pending a claim specific to this message. During electronic adjudication, the pend reason may be attached to the claim if the batch job cannot save the claim in an 'Accept' status due to the warning message's security level. This code is also used to specify claims for automatic release through the Pended Claims Release Parameters application.
Message Text1 Message Text 2	*	Text of the user-defined warning message. This message is created in the User Warning Message Descriptions application, Application Support application group.
Security Level		Defines the security level for the related message. End-users processors and batch jobs must have the same or higher level of security to complete claims processing when the related message is activated. System-defined security levels range from "0" as the highest level to "9" as the lowest level.
Suppress Message during Processing		An indicator that determines if the warning message should be suppressed during processing. Check this box if this warning message should not display during claims processing.
Override Text1		Text entered in this field will replace the text that is identified in the **Message Text1** field.
Override Text2		Text entered in this field will replace the text that is identified in the **Message Text2** field.

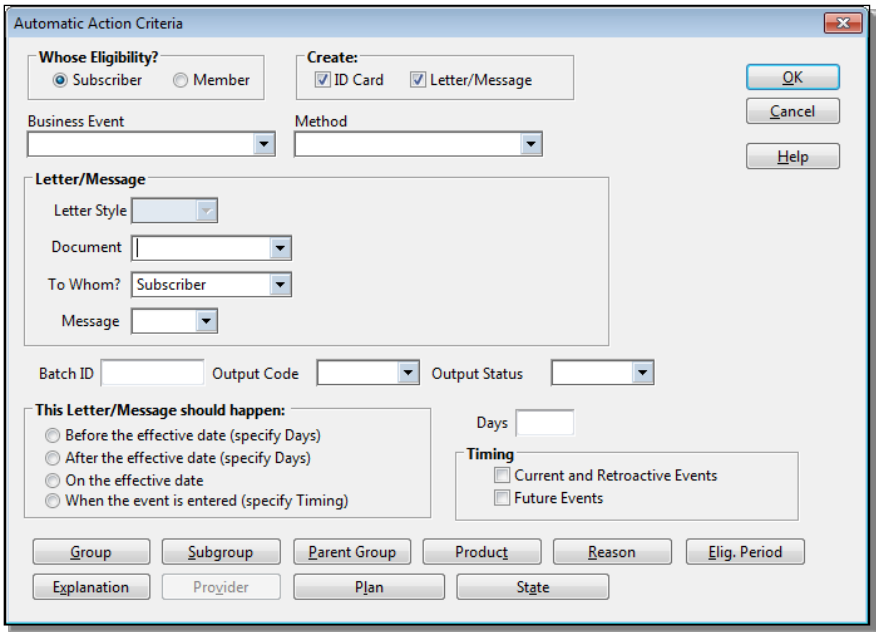
Automatic Action Criteria Application (MCRD)

The Automatic Action Criteria application allows users to create the scenarios specific to the health plan that will result in the production of automatically generated letters, ID card requests, or other output. Users may identify the criteria in the Eligibility, PCP, Membership, and Special Mailing sections that will generate ID card requests, letters, or other output. Users may create both letters and ID cards at the same time.

The text-out area below the grid displays detailed information about the selected 'event' row.

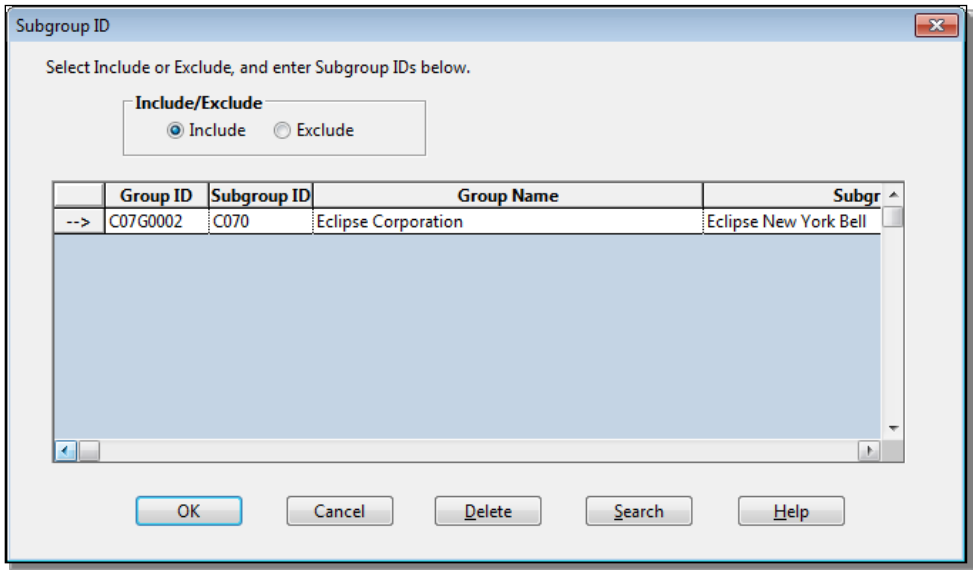
Adding Automatic Action Criteria

Step	Adding Automatic Action Criteria
1	Select **Add** from the **Edit** menu (**Alt+E+A**) to generate an **Automatic Action Criteria** dialog box for either the Eligibility, PCP, Membership, or the Special Mailing sections (see below for the **Eligibility** section).



Step	Adding Automatic Action Criteria (continued)
2	Select **Prefix Description** from the **Edit** menu (**Alt+E+P**) to access the **Prefix Description** dialog box and enter a prefix description for this Automatic Action Criteria prefix, which will appear in the Title bar and the bar above the prefix at the top of the screen.

Step	Adding Automatic Action Criteria (continued)
3	Select Criteria from the **Edit** menu (**Alt+E+C**) to include or exclude certain IDs, prefixes, codes, or time periods from the automatic results batch. Choose the appropriate option to open a criteria dialog box.



The prefix for this application is attached to the Product, **Components** section.

The relationship between the MCRD component and the Subscriber/Family application

The **Auto Actions** section of the Subscriber/Family application offers the ability to view and edit automatic actions generated for a subscriber and/or related member(s) based on Business Events identified at the product level (i.e. Automatic Action Criteria (MCRD) product component application). Facets compares new eligibility, PCP, and membership information for a subscriber or member to the old set of results and the plan parameters. If a match is found that indicates a letter or an action should be generated, an Action row is added to the **Auto Actions** grid. Automatic Actions include letters, ID cards, messages, and reports.

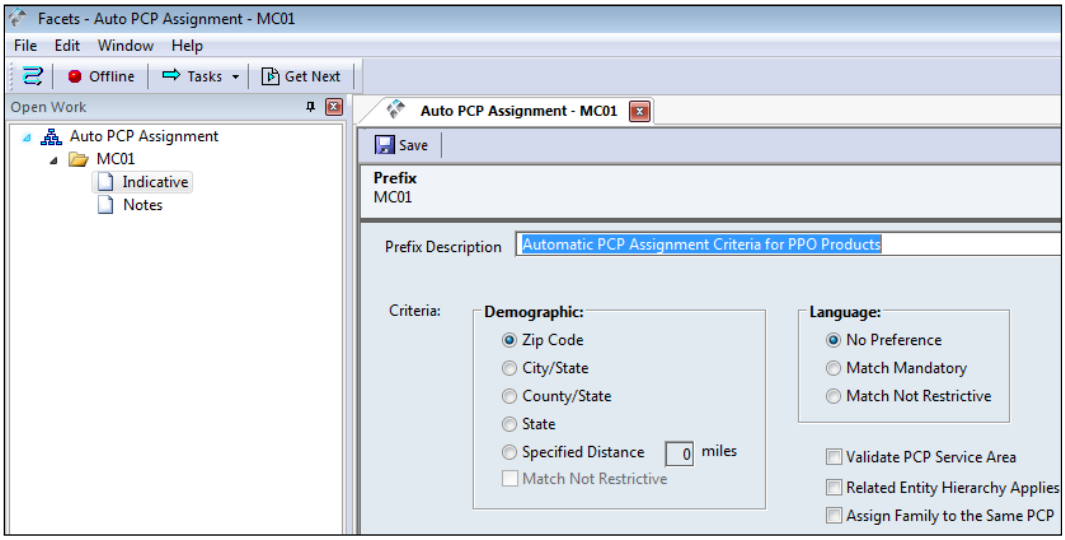
Automatic PCP Assignment Application (MCPA)

Facets allows the user to automatically assign a Primary Care Provider (PCP) to a member. The auto PCP assignment functionality is invoked when a new member is enrolled in a medical product through the Enrollment application, the Subscriber/Family application, or the Membership Maintenance Subsystem (MMS). The member's product must be configured for automatic PCP assignment, must require a member PCP selection and a PCP for the member must not have been entered.

The auto PCP assignment process checks the member's product for the existence of an "MCPA" prefix, which is the Auto PCP Assignment application found in the Medical Plan application group. If one exists, the process then attempts to automatically assign a PCP based on the criteria established on that application.

Indicative Section

This section allows the user to enter a description for this set of automatic PCP assignment criteria and to choose the parameters that will be used to select matching providers for automatic PCP assignment.



Field		Description
Fields denoted with an * are required.		
Prefix Description		Up to 70-alphanumeric characters. Enter a user-defined description for this set of automatic PCP assignment criteria.
Demographic Criteria:	*	Select whether Zip Code, City/State, County/State, State, or Specified Distance/Miles will be included as part of the

		Auto PCP assignment criteria. If Specified Distance/Miles is selected, enter a number (up to 99) to indicate distance in miles in the adjacent field. Zip Code is the default value. Only one demographic criteria value may be selected.
Match Not Restrictive		Check this box to allow Facets to match PCPs using demographic criteria in the Auto PCP Assignment process. If no matching PCPs are found, the criteria is dropped. This option is enabled only when the Specified Distance/Miles option is selected.
Language:	*	Select one of these values to indicate the language preference criteria for the Auto PCP Assignment process.
Validate PCP Service Area		Note: This is part of the Facets Assigned Risk Module.
Related Entity Hierarchy Applies		Check this box to indicate that user-defined related entity favorability ratings are to be factored in the Auto PCP Assignment process.
Assign Family to the Same PCP		Check this box to indicate that the same PCP is to be assigned to all family members in the Auto PCP Assignment process.

Adding an Auto PCP Prefix on the Product

The Component ID for Auto PCP Assignment is “MCPA.”

When adding an MCPA component to a Product, PCPs must be required via the AIAI (Administrative Information) product component listed on the Product.

Note: Auto PCP Assignment displays in the PCP Assignment Source field of the Members section (Subscriber/Family Application), PCP subsection tab when the PCP has been selected through the auto PCP assignment functionality.

Note: A product parameter, **AUTO_ASSIGN_INV_CRIT**, enables users to determine the point at which Auto PCP assignment functionality occurs. In addition, a value on the VALIDATEPCP product parameter enables validation of the PCP service area. Refer to the *SA User Guides* for additional information.

Processing Control Agent Application (PCAG)

This Processing Control Agent (PCA) application was developed to allow users to establish criteria that would interact with the claims and Utilization Management applications to perform specific actions when processing the claim or UM episode. Users are able to enter criteria for automating claims processing workflow and letter generation. The data in this application's Criteria section will specify how claims will be processed and when automatic letter generation will occur. Users may also delete criteria if it is no longer needed.

All entered criteria is tied to a prefix set containing a user-defined Prefix and a selected application. Criteria is entered and edited on the **Processing Control Agent** dialog box and displays in the **Criteria** Section after it has been selected. Users may re-use the same prefix ID for multiple applications. Once created, this prefix for the PCA application will be attached to the product.

Adding or Opening a PCAG record

Step	Adding or Opening a PCAG record
1	Choose **New** or **Open** from the **File** menu (**Ctrl+N or Ctrl+O**).
2	The **New** or **Open** dialog box will display.
3	Enter or assign a prefix to the table.
4	Choose an application from the drop-down menu.

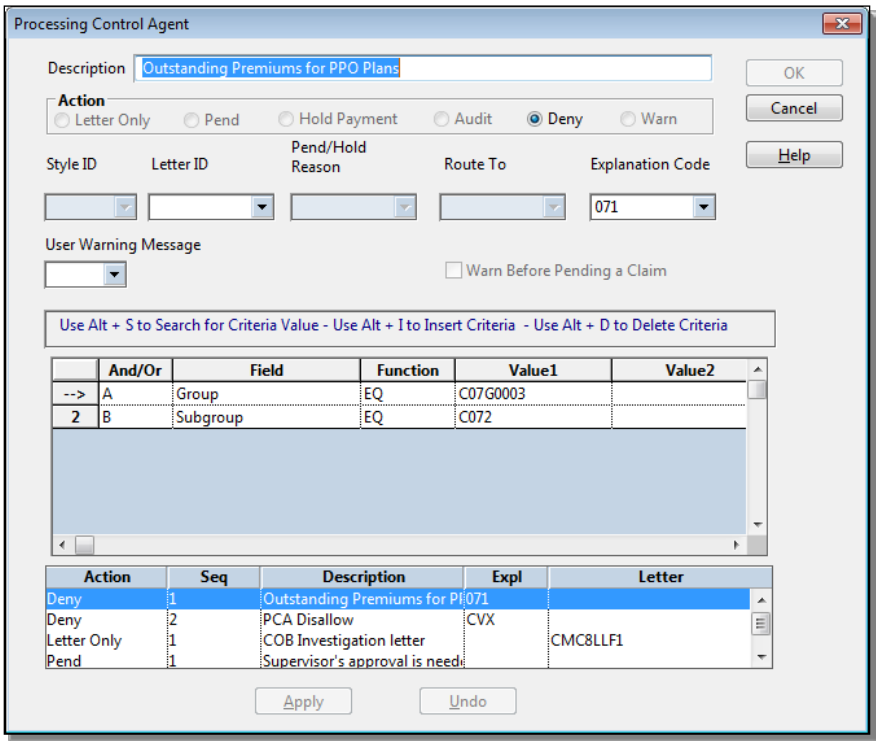
Criteria Section

Use this section to add a new Prefix Set or open an existing Set that contains claims and letter processing criteria. Users may also delete criteria from this section or display the **Processing Control Agent** dialog box to add or insert criteria. Users may also input a Prefix Description to make it easier to search for prefixes.

Button	Description
Add Criteria button	Choose this button to display the **Processing Control Agent** dialog box. This will allow the user to enter criteria.
Insert Criteria button	Choose this button to display the **Processing Control Agent** dialog box to allow a user to insert criteria above the highlighted row.
Delete Criteria button	Choose this button to delete the entered data.

Adding PCA Criteria

Step	Add PCA Criteria rows
1	Select **Add** from the **Edit** menu (**Alt+E+A**) or press the **Add Criteria** button.
2	The **Processing Control Agent** dialog box will appear. Here, users may establish criteria that, when matched to data on a claim or UM episode, will trigger the specified action.



The above example reads as follows:

If the Group ID equals C07G0003 AND the Subgroup ID equals C072, Deny the claim with explanation code 071. In this example, if the claim meets item A and B, Facets will perform the action selected.

Field		Description
Fields denoted with an * are required.		
Description		Enter a description for the “Sequence Number” being established. This description will display on the main **Processing Control Agent** screen.

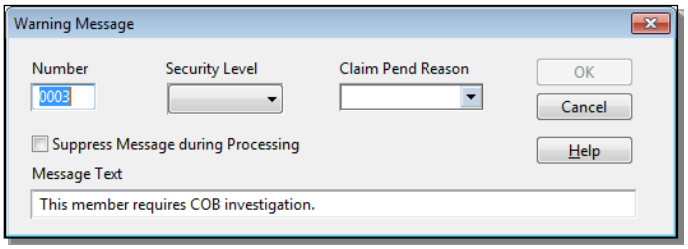
Field		Description
Action:	*	Select the action to be taken when a match is found for the criteria being established. Options include the following:
Action: Letter Only		This action generates letters when criteria on the claim or UM review match with criteria specified in the PCA. **Note**: This is the only available option if the application selected is UM Services or Confinements. When criteria is established, Facets compares the PCA rows to the data on the UM review. Wherever matches occur, letters generate. However, 2-identical letters will not generate on the same date.
Action: Pend		A “Pend” action suspends claims containing line items that match to specified PCA criteria. Member accumulators will not be updated until claims are re-adjudicated for release or are released by the Pended Claims Release Parameters application.
Action: Hold Payment		A “Hold” action suspends claims containing line items matching the specified PCA criteria and updates applicable member accumulators. The claim may later be released through the Payment Drag Override Processing application.
Action: Audit		This suspends claims containing lines matching the criteria for auditing. If “Audit” is selected, users must also select options in the **Pend/Hold Reason** and **Route To** fields. **Note**: Audits can also be based on a random percentage of claims by user ID. This is set-up in System Administration (SA), User Setup application.
Action: Deny		This disallows affected claims that match specified criteria.
Action: Warn		Choose this action to automate the generation of warning messages when the PCA criteria match the data on a claim line. Depending on the security attached to the selected user-warning message, a claim that contains a line that matches specified PCA criteria may be pended.
Style ID		If a letter is being included as part of the action (either via a Letter Only action or attached to a

Field		Description
		Pend, Hold, or Deny Action), select the Style ID for the desired letter.
Letter ID		If a letter is being included as part of the action (either via a “Letter Only” action or attached to a “Pend,” “Hold,” or “Deny” action), select the “Letter ID” for the desired letter. Only those letters that correspond to the “Style” selected will be displayed in the drop-down selection list.
Pend/Hold Reason		If the action selected is “Pend,” “Hold Payment,” or “Audit,” users must select the reason code to be used when pending a claim. This code may later be used to release pended claims in the Pended Claims Release Parameters application.
Route To		If the action selected is “Pend” or “Audit,” users may select a User ID (or User Group) to whom the claim is to be ‘routed.’ **Note**: This field is a required selection for the action of “Audit.”
Explanation Code		If the action is “Deny,” indicate the Explanation Code that will appear on the claim screen as the ‘reason’ for the line-item disallow if a match occurs between a claim line and PCA criteria.
User Warning		Select a user-defined warning message that will display during claims processing when the Processing Control Agent criteria matches a claim line item. **Note**: This field is required if “Warn” is selected and is only available if “Warn” or “Deny” are selected.
Warn Before Pending a Claim		Select this checkbox to generate a warning message when a claim is about to be pended as a result of a match with PCA criteria. Users can review the claim and select the “Bypass PCA Pend” override on the claims processing application, if necessary, so the claim does not pend. This option is only available when the user selects the “Pend” action.
And/Or	*	Select the identifier for the data considered as and/or criteria. Values are A through Z. All identical values represent ‘or’ criteria while each

Field		Description
		non-identical value represents ‘and’ criteria.
Field	*	Choose the field that must be matched in order to invoke the Processing Control Agent action.
Function	*	Select the Function specifying how to calculate entered criteria. **Note**: not all functions are available for all fields. Function values include: GT = Greater Than, EQ = Equal, NE = Not Equal, GE = Greater Than or Equal To, LE = Less Than or Equal To, LT = Less Than, NW = Not Within, and WI = Within.
Value 1	*	Enter the value that, when combined with the field and function, determine if a claim or UM should be selected for PCA processing. When the function is set to WI or NW, this represents the low value in the range. Note: If revenue codes are entered in the ‘Value’ fields, enter a 4-digit code. The UB92 committee requires all revenue codes to be 4-digits. When entering a revenue code in Facets, a leading zero must be added to the code. A three-digit entry generates the following error message, “Revenue Code Not Found.”
Value 2	*	Enter the value which, when combined with the field and function, determine if a claim or UM should be selected for processing by the PCA. When the Function is set to WI or NW, this represents the high value in the range. [Required according to the selection in the **Function** field].
OK button		This displays the **Processing Control Agent** dialog box.
Cancel button		This will close the **Processing Control Agent** dialog box.
Help button		Choose this button to open on-line help for this dialog box.
Apply button		This ‘applies’ criteria to the grid. More than 1-set of criteria may be entered without using the dialog box each time.
Undo button		This cancels the criteria entries; only applicable if the Apply button has not been chosen.

Warning Messages Application (WMWM)

This application is a required product component and allows the user to view warning messages for a product. When a situation occurs in Claims Processing, Clinical Editing, Utilization Management, ITS (Interplan Teleprocessing Systems), or FSA (Flexible Spending Account) that is specific to a warning message, Facets displays the message to assist in detecting the situation.



Field		Description
Fields denoted with an * are required.		
Number	*	Sequence number assigned to this warning message.
Security Level		Defines the security level (linked to the user security indicator) for the related message. Based on the user security structure, some processors may not be able to process when the related message is activated. System-defined security levels begin with “0;” highest level. Security will not affect processing when the message generates.
Claim Pend Reason		Select a user-defined reason for pending a claim specific to this message. Use this code to specify claims for automatic release through the Pended Claims Release Parameters application.
Suppress Message during Processing		An indicator that determines if the warning message should be suppressed during processing. Check this box if this warning message should not display during claims processing.
Message Text	*	The text for this warning message; up to 70-characters.

Indicative Section

This section shows the warning messages Facets may generate for claims processed under plans using this product prefix.

Note: The warning messages above will only display in Claims Processing applications.

Facets Generated Messages

When processing claims, referrals, and pre-authorizations, Facets generates messages pointing out existing situations requiring attention. The specific warning messages are system-defined. While the actual wording of the message can be altered, the intent behind the message is still controlled by Facets. The message will be presented in the original manner regardless of whether the wording has been altered.

Handling Warning Messages

The Warning Messages application enables users to modify the description, suppress the generation of any of these messages, and assign a user security level required by the operator in order to complete a transaction involving a warning situation. Some claims examples include: possible duplicate claim, clinical edits exist, and possible pre-existing condition.

The Warning Messages application allows the user to:

- Determine whether to suppress the message from generating within the application from one product to the next.
- Set the message to a level of security that is either above or below the level of security of each user. This level will be compared against the user's security level when processing to determine whether a claim or UM review should be pended or accepted as complete.
- Identify the appropriate Claim Pend Reason Code that should be associated with this warning message during claims processing.

In order to assist users with the process of automatically releasing claims through the Pended Claims Release Parameters application, each user-warning message can have a corresponding Claim Pend Reason Code that will be generated by Facets as the reason for pending the claim when the warning message is invoked during processing.

Note: The **Claim Pend Reason** drop-down selection is available only when making an entry within the Claims Processing application.

When claims are processed for subscribers enrolled in a product, Facets will check for certain conditions relating to events depicted by these warning messages. Should a warning message be found related to an application on a Warning Messages prefix that is tied to the product, the warning message will appear. Based on an individual's security level, processors will either pend or accept these claims.

Coordination of Benefits (COB) Rules Application (CBCB)

Coordination of benefits (COB) is a procedure for limiting benefits from two or more carriers to 100% of the claimant's covered expenses. Most plans contain a COB provision for two or more carriers to determine their liability and pay all covered expenses without reimbursing either the enrollee or the provider beyond the allowed amount. The National Association of Insurance Commissioners (NAIC) has guidelines establishing the order of benefit determination and administration of duplicate coverage provisions. The order of benefit determination identifies primary and secondary responsibility for reimbursement of expenses. The CBCB is a Product Component that defines rules used when processing claims for members with other insurance.

Note: The COB product component defines rules for coordinating primary & secondary carrier benefits when processing claims. The COB prefix, AGCB, can be attached to a provider's agreement (Related Prefixes section tab). This gives 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).

Indicative Section

This section will list the type of COB rules that have been set-up for the product in the top grid titled "Type". The grid displays the type of coverage to which the set of COB rules apply. This information is entered in the **Coordination of Benefits** dialog box.

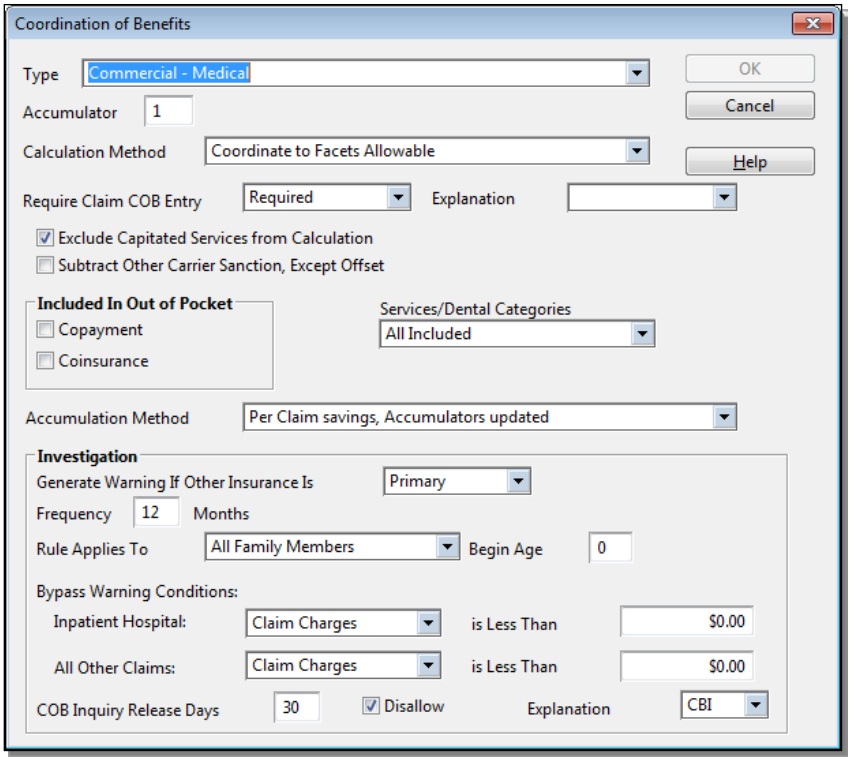
Indicative Section Tab

This section tab displays COB rules applied during claims processing for the coverage type selected in the section grid. Fields display indicating if member COB entry is required for a claim, if the carrier sanction amount should be subtracted from the "Other Carrier Allowed" amount, as well as any bypass warning conditions.

Note: Use this section tab to view the details related to a COB type.

Adding COB Types

Step	Adding COB Types Procedures
1	To add a COB type to the top grid and the rules that should be applied during claims processing, select **Add…Section** from the **Edit** menu (**Alt+E+A+S**) to bring-up a **Coordination of Benefits** dialog box.



Field		Description
Fields denoted with an * are required.		
Type	*	An indicator that identifies the type of coverage or plan that can be affected by COB rules, if the member in the plan is identified as having other insurance. To ensure during claims processing that a mixture of line item services are not all processed under a single COB Type (i.e. the member has Medicare Parts A, B, and D), the user must include the Service IDs for services specific to prescription drug claims in the **Medical Services** section tab. It is recommended that prescription

Field		Description
		drug Service IDs also be excluded from the other COB Types using the **Medical Exceptions** section tab. During claims adjudication, if a claim includes a mixture of 'included' and 'excluded' services (i.e. the claim contains services for both Medicare Part A or B and D as identified in the **Medical Services** and **Medical Exceptions** section tabs), Facets will generate claim level warning message 120, "At least one line item excluded from COB on this claim." The user may choose to split the claim. The value captured in the claim and line level COB tables will still equal the value selected during claims processing.
Accumulator	*	Enter the number (1-99) that will identify the accumulator bucket that stores COB savings when claims are processed and this COB rule is referenced in the adjudication process. This number distinguishes accumulators of the same type (i.e. COB, deductibles, and limits) for each family member.
Calculation Method	*	Identifies the method that Facets will use to perform the COB calculation. **Note**: Option "M" is a calculation method that calculates payment and out-of-pocket amounts in absence of other coverage and uses those amounts when calculating liability on the current claim. The "Accumulation Method" option "R - Plan Year accumulation of savings, no credit from current claim" allows users to exclude savings from prior line items on the current claim from being reimbursed on subsequent line items. This "Accumulation Method" is only available in conjunction with option "M" here in the **Calculation Method** field. When "Modified COB" is selected as the "Calculation Method" and COB applies, Facets adjudicates the claim twice; once to determine what the allowed, deductible, coinsurance, copay and paid amounts would have been in the absence of COB (including plan limits), and once to calculate the COB adjustment based on this logic.
Require Claim COB Entry		Select the indicator that determines the action to take when the member has other primary

Field		Description
		coverage but the claim does not contain 'other carrier' information. Valid values include: • P – Process as Primary • D – Disallow
Explanation		Select the explanation code attached to the disallowed amounts when the member has other primary coverage; 'Other carrier' information is not included on the claim.
Exclude Capitated Services from Calculation		When this option is selected and a claim is received with a line item that is capitated, the COB routine ignores the line item after the COB proration has occurred when calculating the final payable amount.
Subtract Other Carrier Sanction, Except Offset		Select this check box to subtract the value of the Other Carrier Sanction amount from the Other carrier Allowed amount.
Included In Out of Pocket		If "Copayment" and/or "Coinsurance" is/are selected in this field, Facets will deduct these amounts from the COB savings rather than the member's benefit amount if they are not selected.
Services/Dental Categories		Identifies if Facets should include all services, exclude specific services/dental categories, or include specific services/dental categories when processing claims that involve COB. This field works in conjunction with the **Medical Services** and **Dental Categories** section tabs.
Accumulation Method	*	The method for accruing savings toward COB. Valid values: • A - Per Claim savings, Accumulators updated • C - Per Claim savings, Accumulators not updated • P - Plan Year accumulation of savings • R – Plan Year accumulation of savings, no credit from current claim **Note**: Option "R" is only available when the "Calculation Method" is set to "M – Modified COB." If a user attempts to select it in conjunction with any other

Field		Description
		calculation method, the following error message displays: “Accumulation Method Not Valid with Calculation Method Selected.”
Investigation: Generate Warning If Other Insurance Is		This field identifies the ‘order’ condition that will cause Facets to request a COB investigation. When this condition is met during claims processing, Facets will display a warning message. Valid conditions are: P = Primary, S = Secondary, U = Unknown, and A = All (includes all conditions).
Investigation: Frequency __ Months	*	The number of months in the allowable period between COB investigations.
Investigation: Rule Applies To	*	Select the family members who are subject to a COB investigation. Valid values are: • A - All Family Members • S - Spouse Only • D - Dependent Children Only
Investigation: Begin Age	*	Identifies the age (01 to 99) at which children become subject to the COB investigation provision. A begin age must be entered here if this COB provision applies to all family members or dependents only.
Bypass Warning Conditions: Inpatient Hospital		Select the type of threshold to be read for Hospital Inpatient claims. If the threshold type amount falls below the COB threshold amount, the COB warning message, “0003 – COB Investigation Required,” will not generate. Valid values include: A - Claim Allowable or C - Claim Charges.
Bypass Warning Conditions: is Less Than		Enter a monetary amount that would trigger a bypass of the COB warning message when the claim allowable or charges falls below the threshold for hospital inpatient claims.
Bypass Warning Conditions: All Other Claims		Select the type of threshold to be read for medical, dental and hospital outpatient claims. If the threshold type amount falls below the COB threshold amount, the COB warning message,

Field		Description
		"0003 – COB Investigation Required," will not generate. Valid values include: A - Claim Allowable or C - Claim Charges.
Bypass Warning Conditions: is Less Than		Enter the monetary amount that would trigger a bypass of the COB warning message when the claim allowable or charges fall below the threshold for medical, dental and hospital outpatient claims.
COB Inquiry Release Days		Up to 2-numeric characters. Facets allows users to send letters of inquiry (LOI) for a member whose COB information is outdated. The user may specify an elapsed number of days during which time any subsequent claims received may also be held until the COB information has been validated. If updated COB information is not received within a certain number of days, users have the option to disallow all held claims or release them. Enter the number of days to be added to the initial claim date to determine when claims held for letters of inquiry should be released. The Claim LOI Start Date displays in the **Member COB** dialog box of the Sub./Family application, **Members** section, **COB** section tab.
Disallow		Check this box to disallow claims after the calculated release date is reached. If not selected, the claim will release and process normally.
Explanation		Select the explanation code used when the claim is disallowed. This field is available if there is a value in the **COB Inquiry Release Days** field.

Medical Services Section Tab

Field		Description
Fields denoted with an * are required.		
Service ID	*	Enter the service ID code that should either be excluded or included in the COB provisions.
Description	*	Automatically assigned by Facets once a Service ID is entered in the row.

Medical Exceptions Section Tab

This section tab contains an enterable grid that allows the user to designate any service that should be excluded from the current set of COB rules. During claims processing, if the line item Service ID on the claim matches a Service ID that was entered in this section tab, Facets will process the claim based on the designated Reason Code, Action, and Explanation information indicated on the grid. Additionally, this section tab allows the user to do the following:

- Bypass pre-authorization/referral requirements from the secondary carrier and pay the claim through a secondary carrier
- Automatically process denied claims as though the secondary carrier is the primary carrier after the service or category were denied by the primary carrier
- Allow the secondary carrier to automatically deny services that were previously denied by the primary carrier based on user configurable explanation codes

Field		Description
Fields denoted with an * are required.		
Service ID	*	Select the Service ID for which an exception to COB processing applies. **Note**: If the **Service ID** field is left bank and the Action is P – "Pay as Primary" or D – "Disallow", the exception will apply to all services.
Reason Code	*	Required if Action is "D" or "P". Enter the denial or rejection reason code that is combined with the Service ID to trigger an exception to COB processing.
Action	*	Select the action to take during claims processing when a claim contains this combination of Service ID and Reason Code. Values include:

Field		Description
		• D – Disallow: If this action plus the Other Carrier Deductible, Other Carrier Allowable, and Other Carrier Paid fields equal $0, and the other Carrier Reason Code equals the Reason Code entered here, Facets disallows the line item regardless of the other entries in the **Coordination of Benefits** dialog box. The explanation code used will be the one entered in this grid. • E – Exclude: This action allows the entire COB calculation to be bypassed and the line item will process normally as primary, ignoring the entries in the **Other Carrier Deductible**, **Other Carrier Coinsurance**, **Other Carrier Copay**, **Other Carrier Sanction**, **Other Carrier Reason Code**, **Other Carrier Allowed**, and **Other Carrier Paid** fields found in the **Coordination Of Benefits** dialog box in claims processing. • P – Pay as Primary: If this action and the **Other Carrier Deductible**, **Other Carrier Allowable** and **Other Carrier Paid** fields = $0, and the **Other Carrier Reason Code** equals the **Reason Code** entered here, Facets processes normally, ignoring any other entries in the **Coordination Of Benefits** dialog box. **Note**: During claims processing when a claim line contains a service that matches a row in this section tab with an Action of "E – Exclude" and the **Other Carrier Paid** field has a value greater than "0", Facets generates this warning message: "131 – Possible Overpayment due to COB Exclusion".
Explanation	*	Required if the **Action** field is "D". Select the Explanation Code that will generate when a line is disallowed based on the carrier's reason code.

Duplicate Claim Rules, Medical Application (DUMD)

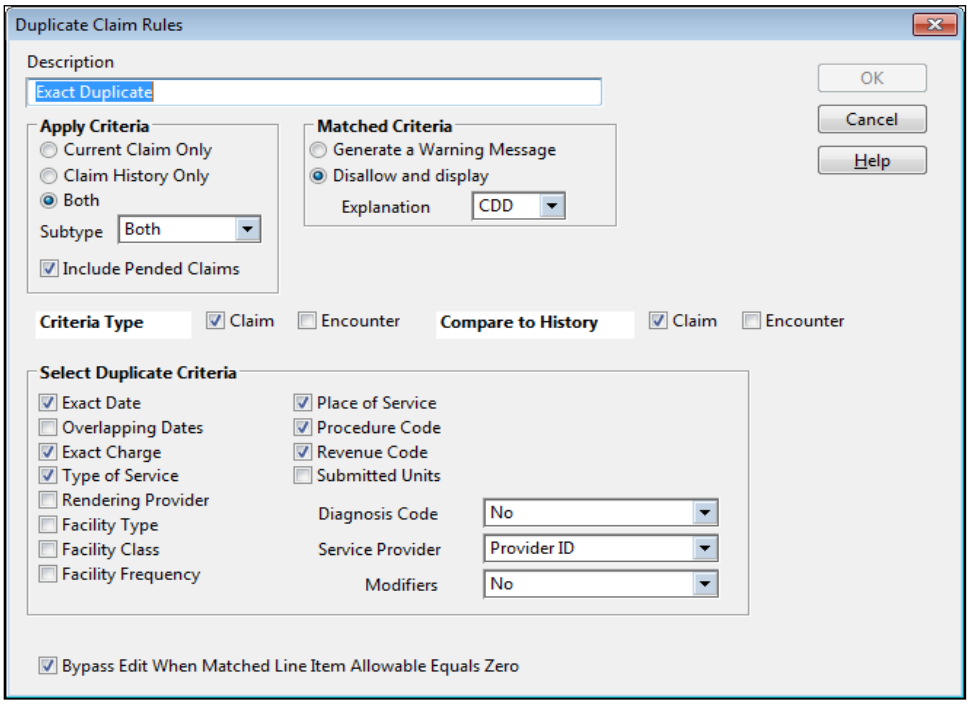
This component defines the rules that constitute a duplicate claim or line item when processing claims. Facets will either warn the user or disallow the claim/line depending on the rule set.

Indicative Section / Indicative Section Tab

This section and section tab shows the duplicate claim rules for all claims processed under plans using this product prefix. The Component ID for this application is DUMD and is required for claims and claims/UM combined products.

The **Duplicate Claim Rules** dialog box allows the user to specify duplicate claim information. Facets will not consider a match found unless all parameters selected in the **Select Duplicate Criteria** area of the dialog box for a given entry have been met.

Select **Add**…**Section** from the **Edit** menu (**Alt+E+A+S**) to enter the data.



Field		Description
Fields denoted with an * are required.		
Description		Enter a description of this duplicate claim edit criteria.
Apply Criteria (radio buttons)		**Current Claim Only**: Match against line items on the current claim only. When set to Current

Field		Description
		Claim Only the Facility Type, Facility Class, and Facility Frequency options are not available. **Claim History Only**: Match against claims in history only. **Both**: Match against current claim line items and claims in history. **Include Pended Claims**: Select this box to include pended claims (status 11 and 15) when reading claim history to determine if the current claim is a duplicate of a claim in history. For example, if claim A exists in history but is pended, and claim B is submitted, claim B is flagged as a duplicate.
Subtype (drop-down)		**Medical Only**: Include only medical claims in duplicate criteria. When set to Medical Only, the Revenue Code, Facility Type, Facility Class, and Facility Frequency options are not available. **Hospital Only**: Include only hospital claims in duplicate criteria. When set to Hospital Only, Rendering Provider is not an option. **Both**: Include both medical and hospital claims in duplicate criteria.
Matched Criteria (radio buttons)		**Generate a Warning Message**: Display a warning message if claim meets duplicate criteria. **Disallow and display**: Disallow line item if claim meets duplicate criteria. **Explanation**: Explanation for disallow.
Criteria Type		**Note**: This option is part of Encounter Processing of the Assigned Risk Module.
Compare to History		**Note**: This option is part of Encounter Processing of the Assigned Risk Module.
Select Duplicate Criteria: Exact Date		Check boxes to include matching criteria for line items in this set of duplicate edit parameters.

Field		Description
Overlapping dates Exact Charge		
Type of Service		Check this box to include matching the type of service for line items in this set of duplicate edit parameters.
Rendering Provider		**Note**: This option is part of Encounter Processing of the Assigned Risk Module.
Facility Type Facility Class Facility Frequency		Check boxes to include matching criteria for line items in this set of duplicate edit parameters.
Place of Service		Check this box to include matching the place of service for line items in this set of duplicate edit parameters.
Procedure Code		Check this box to include matching the procedure code for line items in this set of duplicate edit parameters.
Revenue Code		Check this box to include matching the revenue code for line items in this set of duplicate edit parameters.
Submitted Units		Check this box to include matching the exact submitted units for line items in this set of duplicate edit parameters.
Diagnosis Code		Valid values are: Y – Yes, N – No, and R – Related. Select “Yes” to include the diagnosis code in this set of duplicate edit parameters. This option compares the submitted primary line item or related diagnosis on the current claim or encounter to the submitted primary line item or related diagnosis on other claim lines.
Service Provider		Choose a value to indicate whether a Provider ID or Common Practitioner ID is used in this set of duplicate edit criteria. Options include: • N - No. Do not match the servicing provider. • Y - Provider ID. Match the servicing provider using the Provider ID.

Field		Description
		• C - Common Practitioner, if applicable. If no Common Practitioner ID is found, match the servicing provider using the Provider ID.
Modifiers		Select from the drop-down to include Any, All, or No modifiers in the matching criteria. This selection is only available when the Procedure Code checkbox is selected. **Note**: If **All** is chosen, every modifier on the line must be on both claims, in any order. If **Any** is chosen, at least one modifier on the line of each claim must match.
Bypass Edit When Matched Line Item Allowable Equals Zero		Select this checkbox if the user wants duplicate claims to process normally whenever the duplicate's original claim had an allowable of "0." This may be done for both duplicates set with an action (in the **Matched Criteria** area of the dialog box) of deny/disallow or warn. This capability allows the user to deny the duplicate claim with the same Explanation Code as the original claim, rather than the Explanation attached to the Duplicate Claim Rules.

Generate Warning Section Tab

This tab allows users add, edit, or delete explanation codes used to generate warning messages when a claim has been identified as an exact duplicate to a line item previously disallowed. This determination of whether to disallow or generate a warning on the current claim is based on explanation codes used to disallow line items on the original claim. This logic allows claims to be initially disallowed then resubmitted for review without being automatically disallowed as duplicates.

Explanation of Benefits (EOB) Information Application (EBCL)

This application is a required product component and is attached to the product. It enables Facets to track accumulator updates via the EOB Amounts and Accumulator Data table (CMC_CLEB_EOB_AMTS). Without it, users can still see the totals in the Member and Family Accumulator applications, but Facets will not track the deductible and limits applied to each claim. In addition, the EBCL allows a user to define the deductible and limit accumulation to be printed on the Explanation of Benefits based on an incurred year or lifetime.

Indicative Section

This section allows users to create or change the deductible and limit accumulation information printed on subscriber EOBs. Each combination of accumulator information is tied to a specific product prefix. The actual accumulator amounts are captured and updated when claims related to plans using this product prefix are processed.

Field		Description
Fields denoted with an * are required.		
Type		Indicate Deductible Carryover, Deductible with Carryover or a Limit.
Year Indicator		Choose incurred year or lifetime.
Accumulator		The number assigned to the Accumulator in the Plan.
Max Prefix		Refers to the prefix that has been assigned to the Deductible and Limits records used by the plan. Maximum allowed for a specific Accumulator. Facets will generate a warning message if an invalid prefix is entered.
Display		Required; Select an option to determine which accumulator rows should display on an Explanation of Benefits statement. Yes - All rows will display. No - Only those rows that were updated by adjudication process display.

Service Definition Application (SEDF)

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

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

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

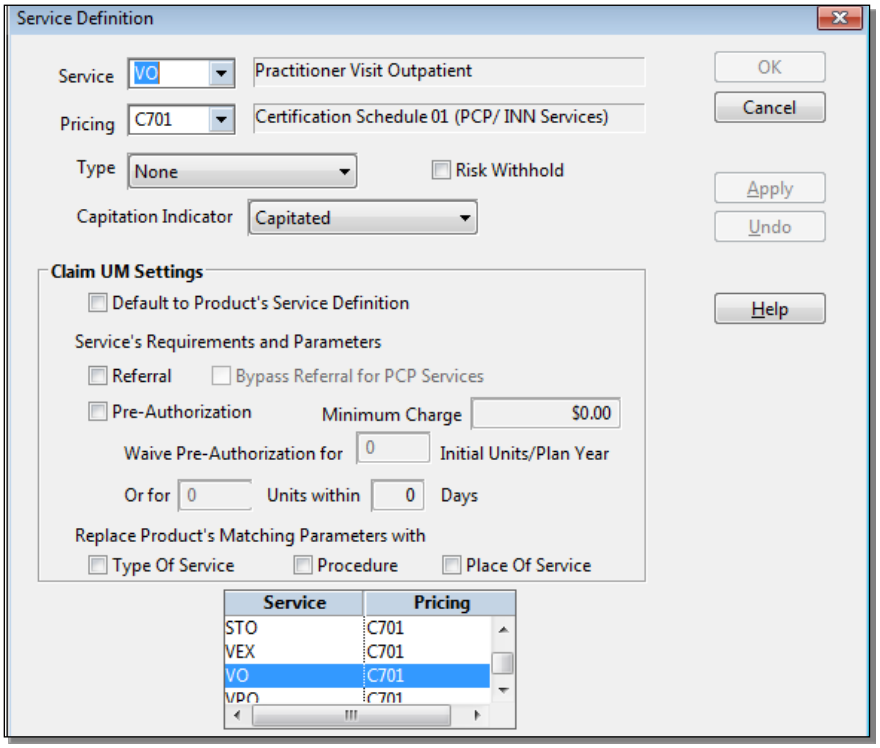
Indicative Section

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

Adding a Service Definition

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

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



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

Field		Description
Fields denoted with an * are required.		
Service	*	Select the Service from the drop-down box.
Pricing	*	Select the Service Pricing record for this service.
Type:		Use this field to select the value that indicates whether the service is a counter-oriented room-and-board service, a primary or secondary service used to calculate per visit pricing

Field		Description
		allowable, a service based-on Ambulatory Surgery Centers (ASC) Primary Procedures, Encounter Units, or Encounter-Ancillary.
Type: Primary and Secondary		Forms the pricing base when both primary and secondary services are performed on a single day and the pricing allowable is linked to the primary service. Secondary services are rolled-up into the primary pricing allowable
Type: Room and Board		This value is used to match UM confinement reviews. If Room and Board types-of-services are not mapped to a Room and Board type, this match will not occur. Also, the **Type of Bill** fields on the **Hospital Claims Processing** screen must equal an in-patient value, which is hard-coded logic.
Type: ASC Primary		This value provides the ability to designate primary procedures for ASC pricing. If a service code is designated as an ASC primary procedure, all other Service Definition types appearing on the claim will roll into this ASC primary procedure.
Type: Encounter Unit and Encounter-Ancillary		A user may define plan limits for benefits that restrict the number of encounters a member has with a provider, yet still allow the provider to furnish a full array of services during those encounters. Therefore, services or diagnoses included will be “rolled-up” into one counter for limit-checking purposes; all treatments performed during one visit to a provider will be counted as one unit. For example, multiple physical therapy modalities performed during a daily visit will be treated as a single unit for benefit limitations and UM requirements.
Risk Withhold		Check this box to indicate a risk withhold is taken from this service.
Capitation Indicator		Select if this service is capitated, prepaid or not capitated.

Field		Description
Claim UM Settings: Default to Product's Service Definition		(For Utilization Management purposes). In claims processing, if the Service Definition read is on the agreement, use the setting on the SEDF attached to product.
Claim UM Settings: Referral		Check this box to indicate this service requires a referral.
Claim UM Settings: Bypass Referral for PCP Services		Check this box to indicate a referral is not required when the service is ordered by the PCP (or a provider covering for the PCP) but not performed by the PCP (or covering provider). If this option is selected, the PCP ID will need to be entered on the claims processing screen in the **Referring Physician ID** field when processing claims for this service code.
Claim UM Settings: Pre-Authorization		Check box; indicates if the service requires a pre-authorization.
Claim UM Settings: Minimum Charge		Enter the pre-authorization dollar threshold for this service.
Claim UM Settings: *Waive Pre-Authorizations for __ Initial Units/Plan Year		Numeric from 0-9,999. Enter the number of initial visits/units for this type-of-service in which pre-authorization requirements will be waived for the plan year.
Claim UM Settings: Or for _ Units		Numeric from 0-9,999. Enter the number of units where pre-authorization requirements will be waived for the specified number of units.
Claim UM Settings: Waive within _Days		Numeric from 0-999. Enter the number of days that pre-authorization requirements will be waived for the specified number of days.
Claim UM		Check the Type-of-Service, Procedure and/or

Field		Description
Settings: Replace Products Matching Parameters with		Place of Service check box(es) to indicate the criteria with this service is used to match claims to UM reviews. Criteria selected here will override matching criteria selected on the Product's Claim UM Matching Parameters (CLUM) application.

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

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

Utilization Management Requirements Hierarchy

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

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

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

7. The provider's record
8. The Procedure UM Definition application/IPMC
9. The Procedure Edit Criteria application/IPCR
10. The Service Definition/SEDF on the Product
11. The Diagnosis Edit Criteria application/IDCR

OON-NetworX*Pricer* Term ID (NSRS)

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

Non Participating Provider Relationship (NPPR)

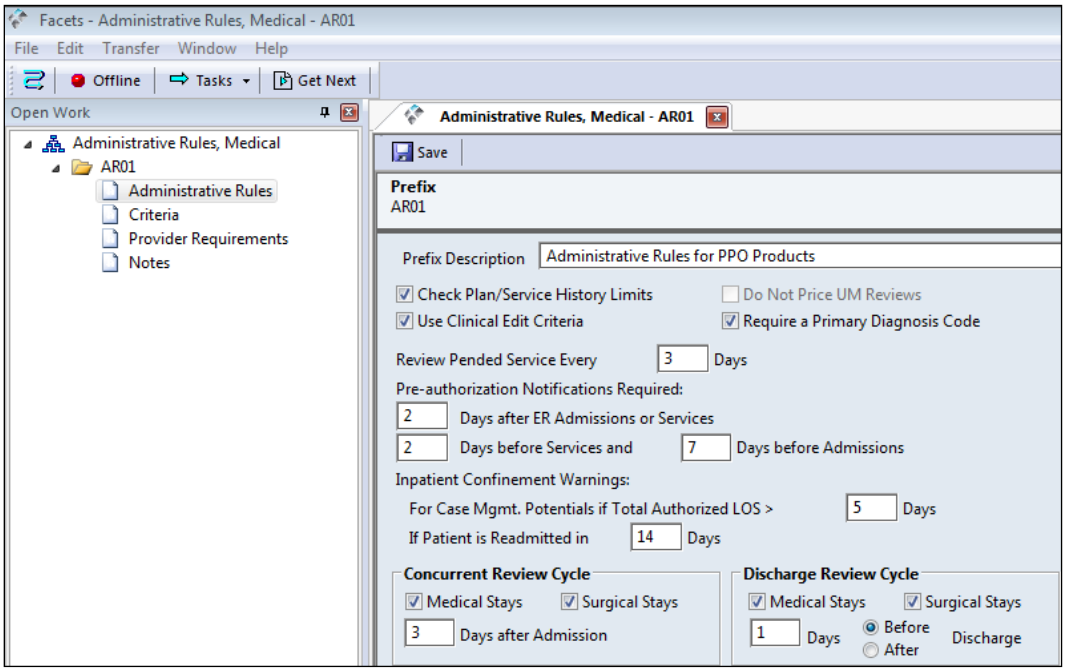
A Non-Participating Provider Relationship prefix (NPPR) is used to link a provider who is not participating in a network to an agreement with a health care plan. The NPPR prefix must first be created in the Component Prefix Descriptions application found in the Medical Plan application group. This prefix can then be linked to the Components section of the Product.

Administrative Rules Application (ARAR)

In this application, the user may indicate when the Prospective UM application should check for plan limits, perform clinical edits, price, require primary diagnosis codes, define what types of providers may request a referral or pre-authorization, indicate whether the provider of service or facility must be participating, determine a review cycle on a plan level, provide timeframes for when a member is required to call the MCO before a service or confinement takes place, and generate some general warning messages.

Administrative Rules Section

This section shows the administrative requirements for all utilization reviews processed under plans that use this product prefix.



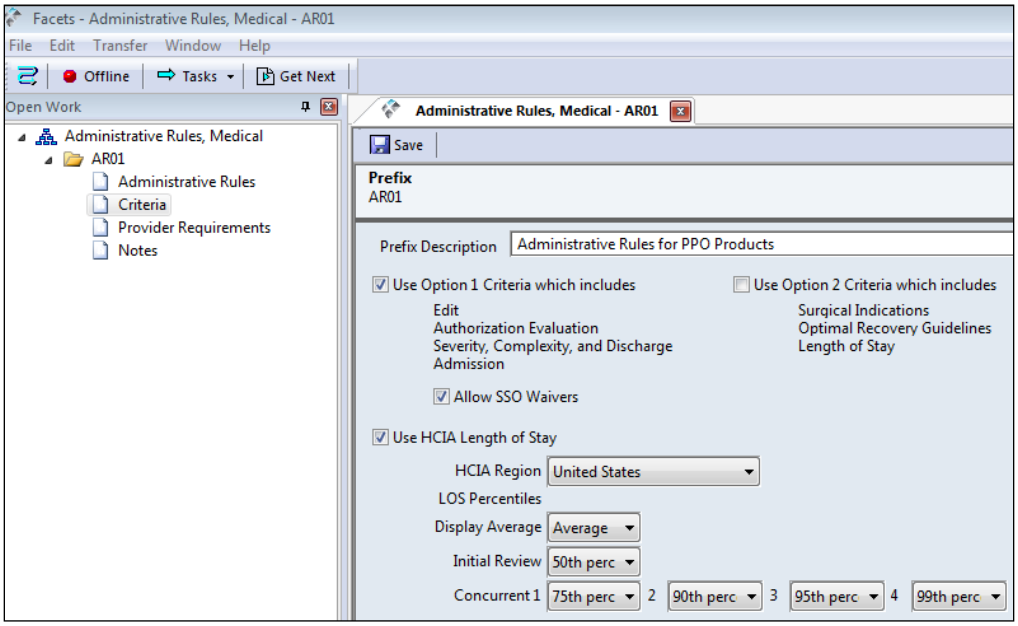
Field		Description
Fields denoted with an * are required.		
Prefix Description		Name of the record; user-defined.
Check Plan & Service		Check this box to review plan and service history limits when pre-authorizing services or documenting a

Field		Description
History Limits		referral. Facets must go through the pricing routine in order to do the limit checking routine because some of the limits may be for amount-oriented services.
Do Not Price UM Reviews		Bypasses the pricing requirements for this product.
Use Clinical Edit Criteria		Reviews clinical edits for pre-authorizations and referrals.
Require a Primary Diagnosis Code		Requires a primary diagnosis for service & inpatient confinement surgical treatment types.
Review Pended Service		Enter the number of days used to calculate a next review date for a pended service if no Next Review Date is entered on the Prospective UM application.
Pre-Authorization Notifications Required: Days after ER Admissions or Services		Type the number of days allowed after emergency services occur and authorization is requested.
Pre-Authorization Notifications Required: Days before Services		Type the minimum number of days before the service date when a pre-authorization must be obtained.
Pre-Authorization Notifications Required: Days before Admissions		Type the minimum number of days before the admission date when an inpatient pre-authorization must be obtained.
Inpatient Confinement Warnings: For Case Mgmt.		Type the number of days to be compared with the authorized length of stay days. If the authorized length of stay is greater than this number, Facets will flag this review for Case Management.

Field		Description
Potentials if Total Authorized LOS > ____ Days		
Inpatient Confinement Warnings: If Patient is Readmitted in ____ Days		Type the number of days between the last discharge date and the next admission date that is the readmission period. If a review is put-in during the readmission period, the user will see a warning message on the UM processing screen.
Concurrent Review Cycle: Medical Stays/Surgical Stays		Check one or both boxes to link the concurrent review cycle to medical or surgical stays.
Concurrent Review Cycle: Days after Admission		Type the number of days following an admission when a concurrent review should occur.
Discharge Review Cycle: Medical Stays/Surgical Stays		Check one or both boxes to link the discharge review cycle to medical or surgical stays.
Discharge Review Cycle: Days Before/After Discharge		Type the number of days either before or after the expected discharge date when the discharge review should occur.

Criteria Section

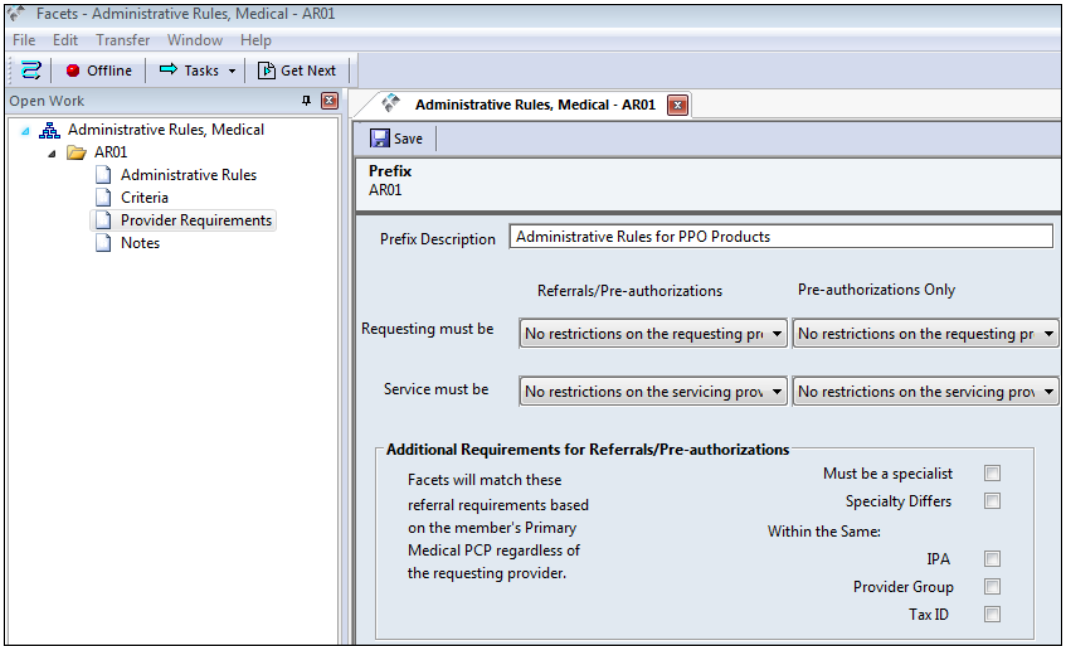
This section defines inpatient and length-of-stay criteria for all the utilization reviews processed under plans that use this product prefix.



Field		Description
Fields denoted with an * are required.		
Use Option 1 Criteria		Standard Deloitte & Touche criteria for diagnoses and procedures supplied with Facets in the Prospective UM application. The standard criteria includes edits for normative age ranges, gender, assistant surgeon, second surgical opinion norms, decision tree evaluation criteria, and severity, complexity, and discharge classifications.
Use Option 2 Criteria		Milliman criteria for diagnosis and procedure codes can be used in Prospective UM. This alternate set of criteria includes surgical/clinical indications for procedures, adequate/inadequate reasons for medical admissions, recommended recovery guidelines, and length of stay information. **Note:** Purchased separately.
Use HCIA Length of Stay		HCIA Length of Stay criteria will be used in Prospective UM for inpatient confinements. The lower the percentile, the tighter the strictness on the number of days allowed. **Note:** Purchased separately.

Provider Requirements Section

General rules can be established to define the criteria that providers must meet to accept referrals and/or pre-authorizations from other providers. Providers can also exclude specific providers from the referral process. During UM processing for referrals, a warning message will display if a servicing provider is not valid for the referring or referred provider.



Field		Description
Fields denoted with an * are required.		
Requesting must be (Referrals/Pre-authorizations)		This is the type of provider authorized to request a referral. If “No restrictions on the requesting provider” is selected, Facets does not care what type of provider makes the request when processing a UM review. If “In-network Only” is selected, the network status of the requesting provider entered must be ‘in-network only or a warning message displays. If “In-network or participating provider” is selected, the provider’s network status must be in-network or participating. Facets checks network affiliations and PCP relationships and displays warning messages, if needed. **Note:** If a participating provider is selected but the provider is out-of-network, Facets will display a warning message.
Requesting		Select the type of provider authorized to request only

Field		Description
must be (Pre-authorizations Only)		pre-authorizations. If “In-network Only” is selected, the network status of the requesting provider entered when processing a UM review must be in-network only, or a warning message generates. If “In-network or Participating” is selected, the requesting provider’s network status must be in-network or participating.
Service must be (Referrals/Pre-authorizations		Select the network requirements for the provider who provides the service. If “In-network Only” is selected, the network status of the servicing provider entered when processing a UM review must also be ‘in-network only’ or Facets generates a warning message. If “In-network or participating provider” is selected, the servicing provider’s network status must be ‘in-network,’ or ‘participating,’ or a warning message will generate. Valid network requirement values for the provider who provides the service include: • I – In network or participating provider • O – In-network Only • S – In Same Network Set • N – No restrictions on the servicing provider
Service must be (Pre-authorizations Only)		Select the restrictions that apply to the servicing provider on a pre-authorization. If “In-network Only” is selected, network status of the servicing provider entered when processing a UM review must also be ‘in-network only’ or a warning message will generate. If “In-network or participating provider” is selected, the servicing provider’s network status must be ‘in-network,’ or ‘participating,’ or a warning message will generate. Valid values include: • I – In-network or participating provider • O – In-network Only • S – In Same Network Set • N – No restrictions on the servicing provider
Additional Requirements for Referrals/Pre-authorizations:		Facets will match these referral requirements based on the member’s Primary Medical PCP regardless of the requesting provider. These requirements pertain to both the PCP and the covering provider. They are "and" requirements.
Must be a		Select this checkbox if the referred or pre-authorized

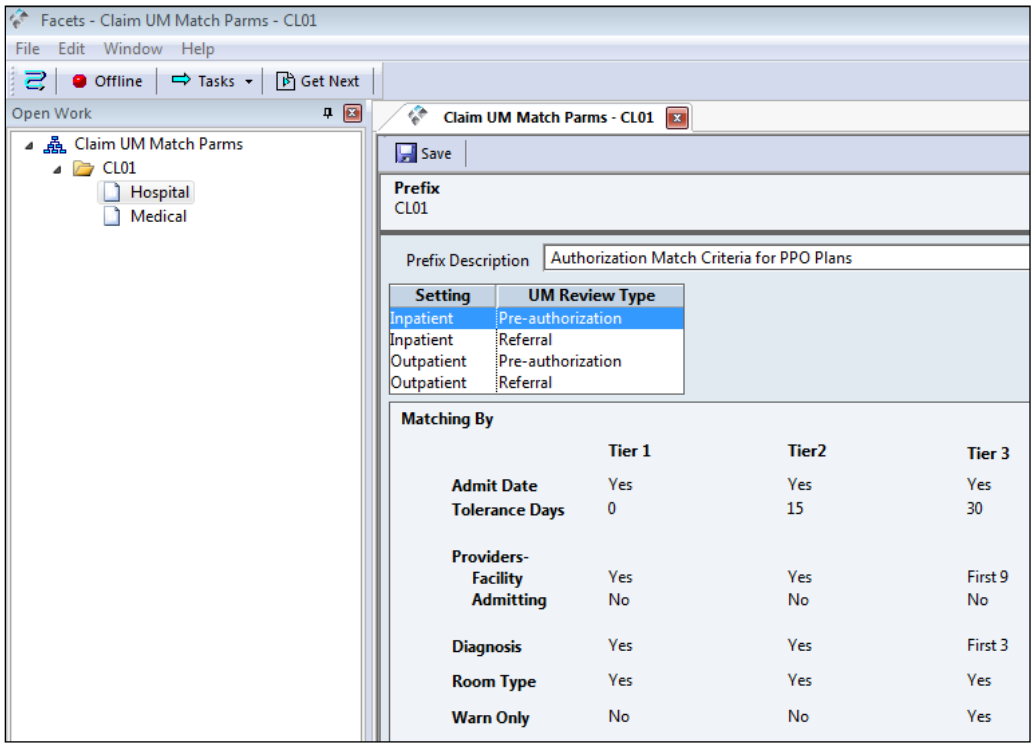
Field		Description
specialist		provider must be a specialist.
Specialty Differs		Select this checkbox if the referred or pre-authorized provider must have a different specialty.
Within the Same IPA		Select this checkbox if the referred or pre-authorized provider must be in the same IPA.
Within the Same Provider Group		Select this checkbox if the referred or pre-authorized provider must be in the same Provider Group.
Within the Same Tax ID		Select this checkbox if the referred or pre-authorized provider must have the same Tax ID number.

Claim UM Match Parameters Application (CLUM)

The Claim UM Match Parameter component allows the user to establish parameters that define an exact match between a claim and a UM review. A claim will match to a UM review based on pre-authorization and/or referral requirements set-up on the Service Definition for that type-of-service.

Hospital Section

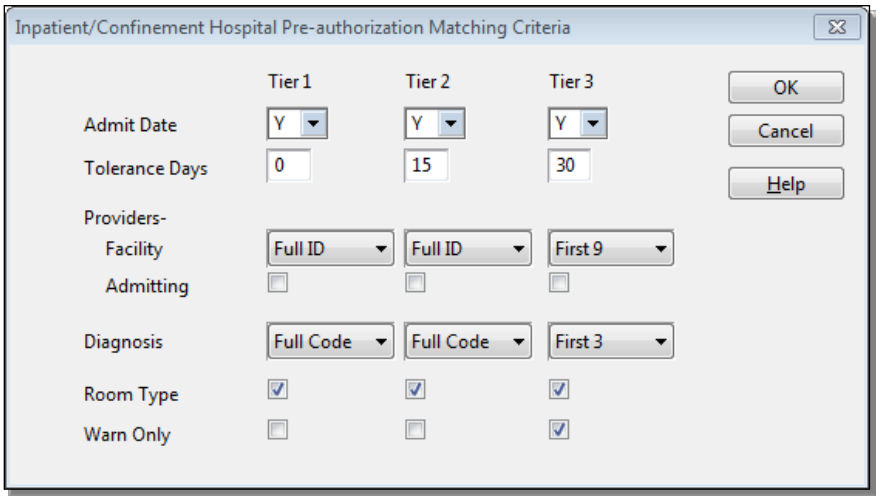
This section allows the user to create or view matching criteria between a hospital claim and a UM review for plans processed under this product prefix. There are 3-tiers of matching criteria. Facets searches tier-1 first to see if a match exists. If a match is not found, it searches tier 2 and then tier 3.



Field		Description
Fields denoted with an * are required.		
Prefix Description		Name of the record; user-defined.
Setting		Place-of-service; in-patient/out-patient.
UM Review Type		Type of UM Required; referral/pre-authorization.

Adding CLUM Matching Criteria

Step	Adding CLUM Matching Criteria Procedures
1	From the **Hospital** or **Medical** section, select **Add Inpatient/Outpatient Confinement/Services Referral/Pre-authorization** from the **Edit** menu to establish matching parameters The dialog box displays.
2	Enter information in the dialog box as described in the field descriptions table.
3	Select **OK**.



Field		Description
Fields denoted with an * are required.		
Admit Date	*	Selection list. The user may specify pre-authorization tolerance days both before and after the admit date. Select one of three values: • Y – Yes. Tolerance days are allowed post-admit dates only. • N – No. No tolerance days are allowed. • T – Tolerance Days, Pre, and Post. Tolerance Days are allowed both before and after the admit date; select this option if the tolerance days are to be applied both pre- and post-admit dates.
Tolerance Days		The number of days to be added to the expected admit date for the requested inpatient stay.
Facility		Match to Facility.

Field		Description
(Providers)		
Admitting (Providers)		Match to admitting physician.
Diagnosis		Match to requested Diagnosis.
Room Type		Match to requested room type.
Warn Only		If “Warn Only” is checked, the system will not automatically perform the match. It will prompt the Claims Examiner to manually perform the match.

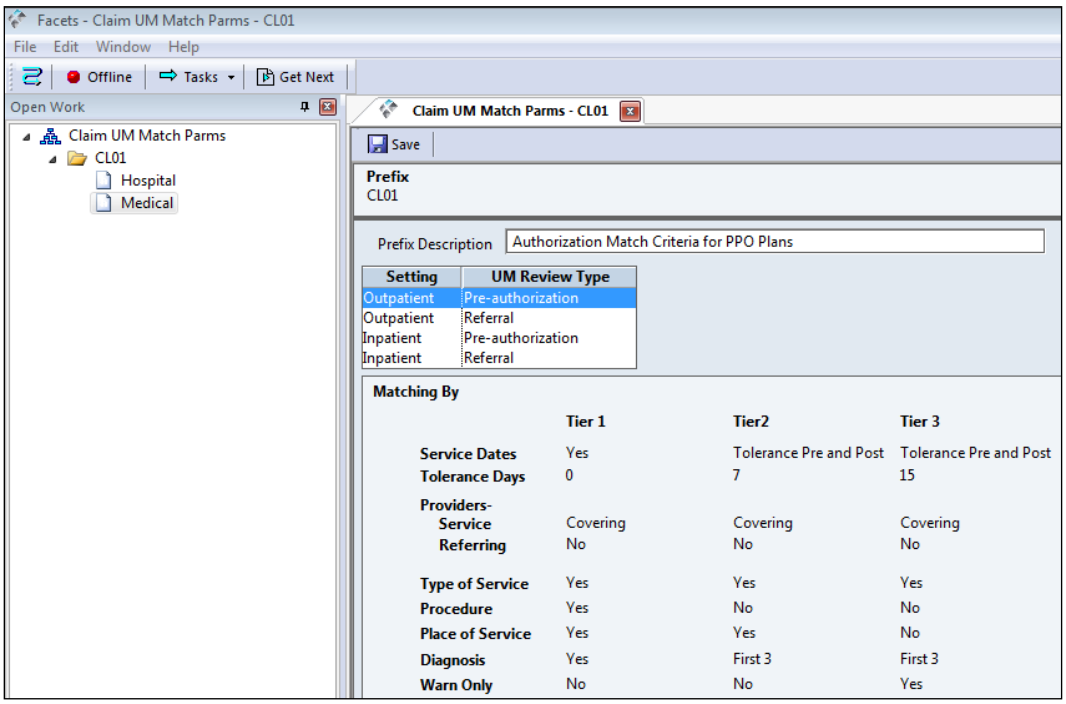
Tiers

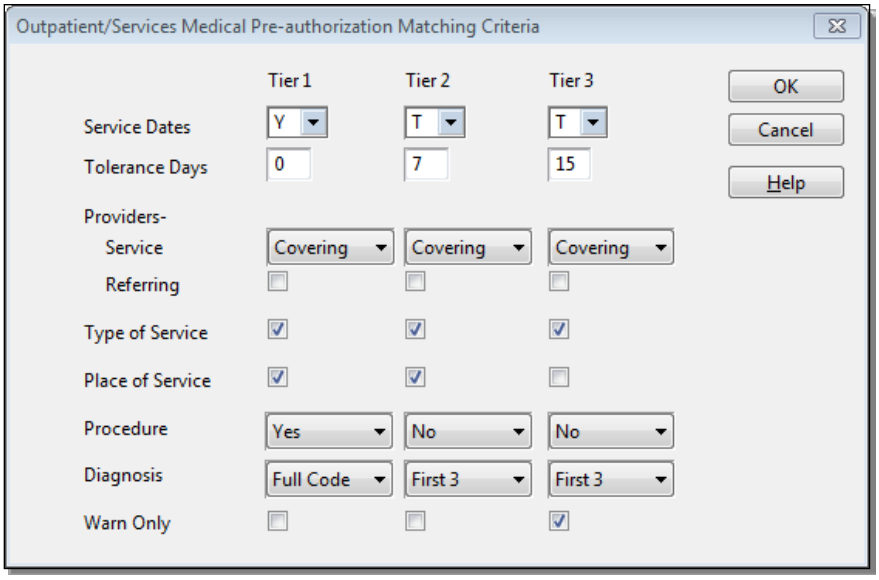
There are three tiers that may be established. It is not required that all three tiers be set-up. Tiers 2 and 3 are optional; they simply allow other possibilities for a claim to match to a UM review. Facets checks against Tier 1 to find a match. If no match is found, Tier 2 and 3 will be checked (if they have been set-up).

Note: The strictest Tier would be listed first.

Medical Section

This section allows the user to create or view matching criteria between a medical claim and a UM review for plans processed under this product prefix. There are 3-tiers of matching criteria. Facets searches Tier-1 first to see if a match exists between a claim and a UM review. If a match is not found, it searches Tier-2 and then Tier-3.





Field		Description
Fields denoted with an * are required.		
Service Dates	*	Selection list. The user may specify pre-authorization tolerance days both before and after the date of service. Select a value: • Y – Yes. Tolerance days are allowed only after (post-service) the specified service dates • N – No. No tolerance days are applied • T – Tolerance, Pre, and Post. Tolerance days are allowed both before and after the service dates; select this option if the tolerance days are to be applied both pre- and post-service dates
Tolerance Days		The number of days to be added to the end of the date-range for the requested date(s)-of-service.
Service (Provider)		Match by requested servicing provider.
Referring (Provider)		Match by referring provider.
Type of Service		Match by requested type-of-service.
Place of Service		Match by requested place-of-service.
Procedure		Select the appropriate dropdown option to match by the requested procedure code. The claim/UM matching

Field		Description
		process can match a claim line containing a 7-digit procedure code (5-digit code with modifier) to a UM service that has a corresponding 5-digit code. This only occurs when a matching UM service row cannot be found with the 7-digit code. This occurs when the “Full/Base” option has been selected. Valid values include: • Yes – match on the exact procedure code • Full/Base – match on full 7-digit code; if no match, attempt to match on base 5-digit code • No – do not match on procedure code (default) These options are found on the **Hospital Outpatient** dialog boxes and all **Medical** dialog boxes. **Note:** When Modifier Hierarchy is being used, the full 7-digit code used will continue to be the 5-digit procedure code plus the modifier re-sequenced into the first position. UM episodes will be decremented when the 7-digit procedure code matches to a 5-digit procedure code.
Diagnosis		Match by requested diagnosis.
Warn Only		If “Warn Only” is checked, the system will display a warning message and will not automatically perform the match; it will prompt the examiner to manually perform the match.

Tiers

There are three tiers that may be established. It is not required that all three tiers be set-up. Tiers 2 and 3 are optional; they simply allow other possibilities for a claim to match to a UM review. Facets checks against Tier 1 to find a match. If no match is found, Tiers 2 and 3 will be checked (if they have been set-up).

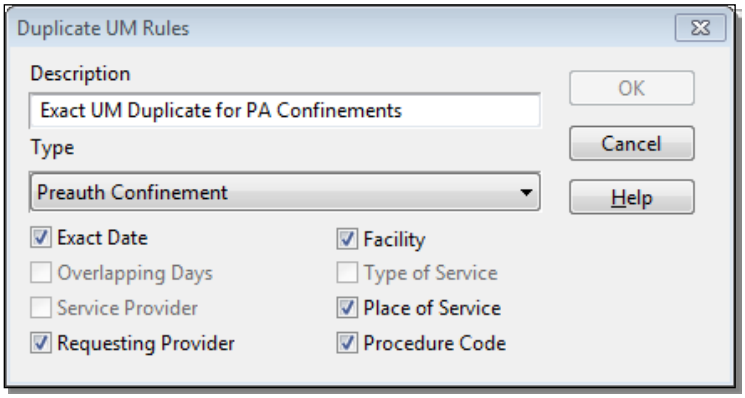
Note: The strictest Tier would be listed first.

Duplicate UM Rules Application (DUUM)

The system will use criteria entered in this application during Utilization Management processing to determine if the review is a duplicate of a review previously processed.

Adding Duplicate UM Criteria

Step	Adding Duplicate UM Criteria Procedures
1	Select **Add** from the **Edit** menu (**Alt+E+A**). The **Duplicate UM Rules** dialog box displays.



Step	Adding Duplicate UM Criteria Procedures (continued)
2	Enter duplicate criteria for UM reviews.
3	Select **OK**.

Field		Description
Fields denoted with an * are required.		
Description		Free-form field; enter up to 70-characters.
Type	*	Select the type of review that applies.
Exact Date, Overlapping Days, Service Provider, Requesting Provider, Facility, Type of Service, Place of Service, Procedure Code		Check the appropriate box to have the duplicate edit match on the selected criteria.

UM Service Group Application (SEGR)

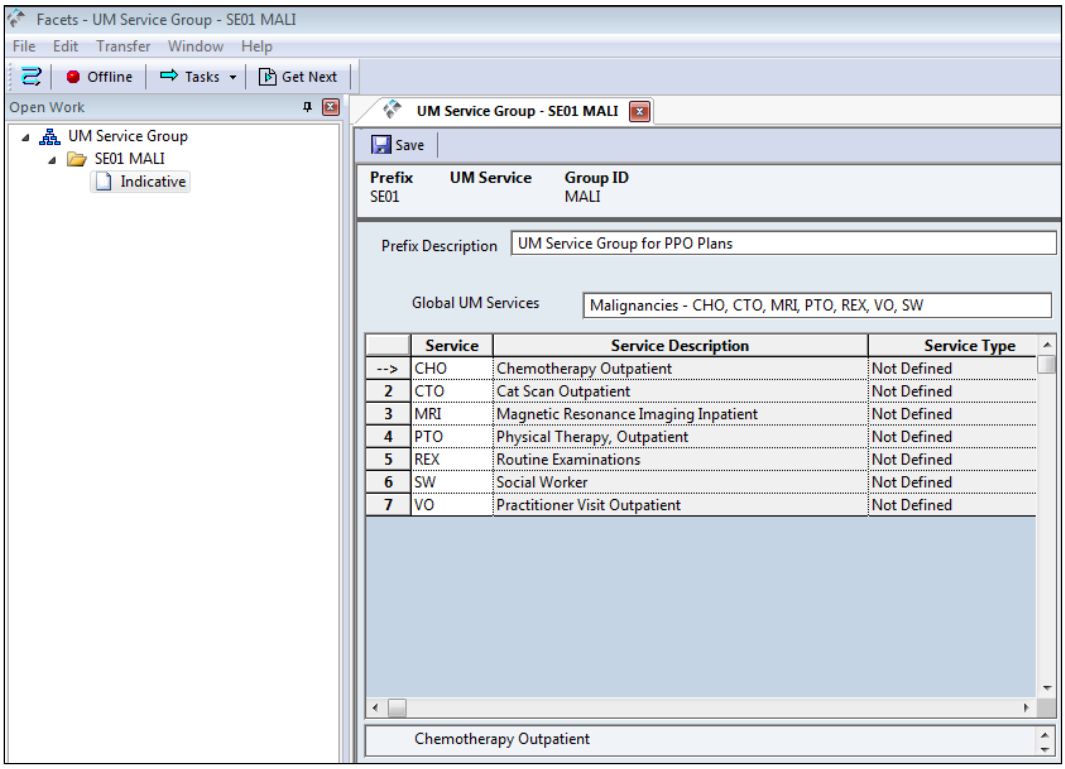
The UM Service Group application allows a user to establish sets of services that include all professional components (services) involved in a patient's care, as well as treatment for a specific specialty type. A set of services may be specific to a patient's age, place-of-service, type of care, and type of treatment. For example, one set of services may be appropriate for elective pediatric surgical admissions, while another set of services may be appropriate for the treatment of cancer.

Before setting up a UM service group, it is necessary to first define the services to be used for the Product. The UM Service Group application is optional. After creation, attach it to the **Components** section of the product.

The user may create several service groups, but all will have the same prefix, which is attached to the product. Enter the UM Service Group ID on the Prospective UM record when processing a review. The user will enter the number of units/visits authorized for this review; the number encompasses all the services indicated for this service group.

Indicative Section

This section allows the user to create or view the UM Service Group prefix and service sets.



Field		Description
Fields denoted with an * are required.		
Prefix Description		User defined description for the Prefix.
Global UM Services		User Defined description for the UM Service Group.
Service		Select the type(s) of Service that will be included in this Service Group; The type-of-service ID must first be defined in the Service ID Descriptions application.
Service Description		User defined description (previously defined) will display when a Service is selected.
Service Type		Used to further classify a Service for Clinical Editing, since the same CPT code can be used to report multiple types-of-service. This is found in the Service ID Description table.

UM Service Groups during claims to UM matching routine

If Facets is looking for matches to a non Room-and-Board Type-of-Service (TOS), it will also check for matches to a UM Service Group. If the matching criteria includes a Type-of-Service match identified at the Service Definition or Claim UM Matching Parameters level and does not find an exact match, Facets will check for UM Service rows with a UM Service Group that might otherwise meet the matching criteria. If a row is found, the system will compare the TOS identified on the claim with the TOS identified in the UM Service Group. If a match is found, the system will assume that the Service row is a match with the claim. If a match is not found, the system will continue trying to match the claim to a UM Service row using the next tier of criteria.