

**BASIC
INSURANCE
CONCEPTS**

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Overview

Description

Understanding basic insurance types is critical if patients are to be registered and billed correctly. This course reviews all commercial and publicly funded (government) types of insurances and the different billing and registration requirements.

Prerequisites

None

Recommended Audience

Target Audience:

- Admitting, Registration and Billing Follow-up management and staff

Also recommended for:

- Social workers
 - Patient and Community Relations
 - Clinical staff who have patient contact
-

Objectives

At the end of this training, you will be able to:

- Define basic insurance terms and explain basic insurance concepts
 - Define all commercial and publicly funded (government) insurance types
 - Demonstrate the ability to interpret insurance cards in order to identify payor, billing address, subscriber and all relevant insurance information
 - Determine payor priority
-

Completion Requirements

Score 80% or above on the post-instruction proficiency examination.

Health Insurance Terminology

All health insurance has rules. If the rules are followed, the health insurance upholds their obligation to provide payment (reimbursement) or partial payment for health care. If the rules are not followed the health insurance does not provide prompt payment and sometimes no payment. Occasionally, the patient is responsible for the entire health care bill.

Our goal is to understand the different types of health insurance. Learn the rules in order to assist patients in understanding their insurance coverage, and to obtain payment from health insurance companies and public programs.

Basic Insurance Terminology

Health Insurance

Pays all or some portion of medical bills

Two major categories:

- Commercial
 - Publicly funded (government)
-

Commercial Health Insurance

- Product sold by for-profit companies
 - Purchased by individuals or by employers
 - Most often obtained as an employment benefit
-

Publicly Funded Health Insurance

- Uses federal, state and local monies to provide health care
 - Provides health care according to various guidelines
 - In general, the state and county programs are available to those ineligible for, or unable to afford, commercial insurance
-

Member

- Anyone covered by health insurance
-

Subscriber

- Person who obtains the health insurance through employment or by purchasing it or by qualifying for a publicly funded program
 - Often a subscriber also obtains health insurance for a spouse/partner and/or any qualifying dependents
-

Premium

- Amount paid to insurance company in order to obtain the health insurance coverage
- Usually paid monthly

Types of Insurance Coverage

Fee-for-Service

- Traditional insurance plan
 - The health insurance company or publicly funded program pays all or part of a patient's medical bills with very few limitations on where the health care is received
 - Few rules
 - Some insurance plans still function this way
-

Managed Care

- Current trend for health insurance companies and publicly funded programs to control cost
 - Several different managed care models
 - Rules that place important limitations on where health care is received and reimbursement amounts are expected
-

Non-Managed Care

- Patient has the freedom to choose when and where they receive medical care without losing total coverage
- Patient liability may change

Insurance Rules

Insurance rules define patient liability, classify providers into different groups and define documentation necessary for coverage. Each insurance rule is explained beginning with Additional Costs – Patient Liability below.

Additional Costs – Patient Liability

In addition to an insurance premium, insurance rules may dictate that a patient has additional costs if they receive services.

Deductible

- Patient must pay a specific dollar amount towards his/her medical expenses before the insurance covers services
 - Usually annual
 - If the patient has no medical care for the year, there is nothing to pay
 - If the patient has medical care, he/she is required to pay for services until the amount paid equals the amount of his/her deductible
-

Co-Insurance

- Patient must pay the portion of medical bill not covered by his/her insurance plan
 - Usually a percentage
-

Co-Payment (Co-pay)

- Patient must pay a specific dollar amount for a certain type of visit – Example: basic office visit to a provider
- Usually collected at the time of the visit instead of being billed to the patient

Provider Classifications

Insurance plans may classify providers into different groups.

Preferred Providers or Network Providers

- Medical providers who sign a contract with insurance companies
 - Sometimes the contract is handled through an intermediary company called a **Network**
-

Primary Medical Group (PMG)

- A group of medical service providers who have joined together and contracted with insurance companies to provide care for managed care patients
 - Patients must receive services with the PMG, in most cases
 - Another term used for this type of provider group is **Independent Practice Association (IPA)**
-

Primary Care Provider (PCP)

- Coordinates all of the patient's medical care
- Regulates the patient's access to medical care
- The PCP can be a:
 - General practitioner
 - Obstetrician/Gynecologist
 - Internist
 - Pediatrician
 - Family practitioner
 - Medical clinic
- Sometime called a "gatekeeper"

Required Documentation

Often an insurance plan requires specific documentation.

Referral

- A document or verbal statement from one medical provider to another medical provider regarding the medical care the patient is to receive
 - **NOT** a statement of the insurance company's financial responsibility
-

Authorization

- Sometimes a written document
- Usually includes a unique identifying number
- Permission for treatment or a procedure
- Necessary for the insurance plan to pay for the service

Commercial Health Insurance Plans

Different commercial insurance plans have different rules. It is important to understand the rules for each type of insurance. Different insurance plans also require different billing procedures. The following section defines the rules for each type of insurance and specifies where bills are usually sent.

Types of Commercial Health Insurance Plans

- Indemnity
 - Preferred Provider Organization (PPO)
 - Health Maintenance Organization (HMO)
 - Point of Service (POS)
 - Exclusive Provider Organization (EPO)
 - Workers' Compensation
-
-

Indemnity

- Fee-for-Service
- Very few restrictions

Category	Definition
Patient Liability	<ul style="list-style-type: none">▪ Yearly deductible▪ Co-insurance for most services (usually 20%)
Classification of Providers	<ul style="list-style-type: none">▪ Any licensed provider
Required Documentation	<ul style="list-style-type: none">▪ May need authorization for costly outpatient procedures▪ May need pre-approval for inpatient services
Send Claim To	<ul style="list-style-type: none">▪ Insurance company

Preferred Provider Organization (PPO)

- Few restrictions
- Contracted (network) providers agree to discount charges (contractual allowances) for the company's PPO patients
- UCSF is a contracted provider with most major insurance companies
- High deductible plans

Category	Definition
Patient Liability	<ul style="list-style-type: none">▪ Yearly deductible – lower if seeing a preferred provider▪ Co-insurance for most services – lower if seeing a preferred provider▪ May also have a co-pay
Classification of Providers	<ul style="list-style-type: none">▪ Preferred Provider – Network or contracted provider▪ Non-Preferred Provider – Out-of-Network or non-contracted provider
Required Documentation	<ul style="list-style-type: none">▪ May need authorization for costly outpatient procedures▪ May need pre-approval for inpatient services
Send Claim To	<ul style="list-style-type: none">▪ Insurance company or network or employer/union

Important information about PPO plans

For patients with high deductible PPO plans, UCSF recommends collecting a realistic deposit amount at the time of service. This deposit must be an estimate of the patient's liability and **must not** exceed the patient's expected financial responsibility.

Health Maintenance Organization (HMO)

- Most restrictive insurance plan
- Patients must choose a Primary Care Provider (PCP)
- All services must be provided by or through referral/authorization of the PCP

There are two types of HMO plans:

- HMO Medical Group Model
- HMO Staff Model

HMO – Medical Group Model

- Patient must choose a:
 - Primary Care Provider (PCP)
 - Primary Medical Group (PMG) or an Independent Practice Association (IPA)
- In most cases, patients must receive services within the PMG
- Determining the patient's PMG is essential

Category	Definition
Patient Liability	<ul style="list-style-type: none">▪ Copay only
Classification of Providers	<ul style="list-style-type: none">▪ Primary Care Provider (PCP) for any medical problem▪ PCP refers/authorizes for ancillary and specialty services, usually within the Primary Medical Group (PMG)
Required Documentation	<ul style="list-style-type: none">▪ Referral for specialty services within PMG▪ Authorizations for high dollar procedures and any services outside the PMG. Authorizations are obtained at the request of the PCP from the PMG and/or insurance company▪ Need pre-approval for inpatient services and some outpatient services
Send Claim To	<ul style="list-style-type: none">▪ Primary Medical Group for outpatient claims▪ Insurance plan for some inpatient claims

HMO – Staff Model

- All services provided by staff hired directly by the insurance company
- Patient must choose a Primary Care Provider
- HMO Staff Model patients **must** have an authorization for all services received at UCSF

Example: Kaiser Permanente HMO

Category	Definition
Patient Liability	<ul style="list-style-type: none">▪ Copay only
Classification of Providers	<ul style="list-style-type: none">▪ Primary Care Provider (PCP) for any medical problem▪ PCP refers/authorizes for ancillary and specialty services, within the group of staff HMO
Required Documentation	<ul style="list-style-type: none">▪ Authorization for all services at UCSF
Send Claim To	<ul style="list-style-type: none">▪ HMO insurance company

Point of Service (POS)

- Most versatile type of insurance
- POS plans have “tiers” also called “levels” or “options”
- The patient decides which tier/level/option to use each time he or she seeks medical services
- Each tier has different rules
- It is essential to determine which tier the patient is using because different rules must be followed

There are two types of HMO plans:

- Three Tier
- Two Tier

The POS Three and Two Tier model insurances are explained beginning on the next page.

POS – Three Tier Model

Tier 1

- Works exactly like an HMO:
 - Patient has a PCP and PMG
 - Patient is responsible only for co-pays
 - Patient must have a referral or authorization for specialty and ancillary services

Tier 2

- Works exactly like a PPO In-network:
 - Patient may self-refer to any provider contracted with the insurance company

Tier 3

- Works exactly like a PPO Out-of-Network:
 - Patient may self-refer to any provider who is not contracted with the insurance company
 - Patient is responsible for an annual deductible and co-insurance payment greater than those with Tier 2.

Category	Definition
Patient Liability	<p><u>Tier 1</u> = Copay</p> <p><u>Tier 2</u> = yearly deductible and co-insurance for each service</p> <p><u>Tier 3</u> = yearly deductible and co-insurance for each service at a higher rate than Tier 2</p>
Classification of Providers	<p><u>Tier 1</u> = PCP, PMG</p> <p><u>Tier 2</u> = Preferred/In-network providers</p> <p><u>Tier 3</u> = Non-Preferred/Out-of-Network providers</p>
Required Documentation	<p><u>Tier 1</u> =</p> <ul style="list-style-type: none"> ▪ Referral for specialty services within PMG ▪ Authorizations for high dollar procedures and any services outside PMG ▪ Authorizations are obtained at the request of the PCP from the PMG and/or insurance company ▪ Need pre-approval for inpatient services
Send Claim To	<p><u>Tier 1</u> = PMG</p> <p><u>Tier 2</u> = Insurance company or network</p> <p><u>Tier 3</u> = Insurance company or network</p>

POS – Two Tier Model

Tier 1

- Works exactly like an HMO:
 - Patient has a PCP and PMG
 - Patient is responsible only for co-pays
 - Patient must have a referral or authorization for specialty and ancillary services

Tier 2

- Works exactly like an Indemnity plan:
 - Patient may self-refer to any licensed provider

Category	Definition
Patient Liability	<u>Tier 1</u> = Copay <u>Tier 2</u> = yearly deductible and co-insurance for each service
Classification of Providers	<u>Tier 1</u> = PCP, PMG <u>Tier 2</u> = Any licensed provider
Required Documentation	<u>Tier 1</u> = <ul style="list-style-type: none">▪ Referral for specialty services within PMG▪ Authorizations for high dollar procedures and any services outside PMG▪ Authorizations are obtained at the request of the PCP from the PMG and/or insurance company▪ Need pre-approval for inpatient services
Send Claim To	<u>Tier 1</u> = PMG or insurance company or network <u>Tier 2</u> = Insurance company

Exclusive Provider Organization (EPO)

- Least standardized type of insurance
- Different EPO plans have different rules
- Some plans are more restrictive than others
- Insurance company contracts with providers not with medical groups, these providers are called “exclusive”
- Exclusive (contracted/network) providers agree to discount charges (contractual allowance) for the company’s EPO patients
- In most cases, the patient may only see exclusive providers

Category	Definition
Patient Liability	<ul style="list-style-type: none">▪ <u>May have:</u><ul style="list-style-type: none">▪ yearly deductible▪ co-insurance for each service▪ co-pay
Classification of Providers	<ul style="list-style-type: none">▪ Primary Care Provider (PCP) for any medical problem▪ Care usually provided by exclusive (contracted) providers
Required Documentation	<ul style="list-style-type: none">▪ May require referral or authorization for specialty care from an exclusive provider▪ Must have an authorization for specialty care from non-exclusive providers
Send Claim To	<ul style="list-style-type: none">▪ Insurance company or network

Workers' Compensation

- Covers medical services for job-related injury or illness
- Employees must follow the appropriate procedure, as determined by his or her employer, in order to receive Workers' Compensation benefits
- Often includes filing a claim
- When patient is treated at onset of injury/illness a Doctor's First Report is required

Category	Definition
Patient Liability	No patient liability
Classification of Providers	<ul style="list-style-type: none">▪ Providers may or may not be contracted with Workers' Compensation company▪ If provider is not contracted, employee must have a letter on file at employer's worksite specifically requesting this facility▪ Employee may use any provider after a designated period of time following the injury – usually thirty days.
Required Documentation	<ul style="list-style-type: none">▪ Must have date/type of injury▪ May have a claim number▪ May have name of claim administrator
Send Claim To	<ul style="list-style-type: none">▪ Insurance company or network▪ Employer if self-funded

What To Look For On Commercial Health Insurance Cards

Commercial health insurance cards provide important information regarding a patient's type of health insurance. This section explains what details on an insurance card indicate the type of insurance plan.

Indemnity Card

- Sometimes the word “Indemnity” is on the card
- If the card does not indicate Indemnity, look for the absence of language indicating another type of insurance

For example:

- Network
- Co-pay
- Tier
- PMG or PCP

PPO Card

- Sometimes the insurance card states:
 - That the plan is a PPO
 - The network name, when applicable
- If the card does not indicate PPO, look for:
 - Words like, “Network/Non-Network”, “Preferred/Non-Preferred”, or “Prudent Buyer”
 - Instructions such as “To maximize your benefits, use participating providers and hospitals”
- Some PPO plans have an office visit co-pay amount

HMO Card

- The insurance card may state HMO
- If the card does not indicate HMO, look for:
 - A PMG and/or PCP
 - Instructions such as “In order to be covered by this insurance, all medical and hospital services must be rendered or authorized by the PMG”
- An office visit co-pay may be listed on the card

POS Card

- The insurance card may state POS
- Sometimes the insurance card states the name of the network, when applicable
- If the card does not indicate POS, look for:
 - A PMG and/or PCP
 - Words like “Triple Option”, “Tier”, or “Plan”
 - Language explaining the different levels of coverage, sometimes stated as having an HMO-like option and a PPO-like option
 - Instructions such as “In order to receive the highest level of benefits, care must be provided by or referred by your Primary Care Physician”
 - Office visit co-pay

EPO Card

- The insurance card may state EPO
- Sometimes the insurance card states the name of the network, when applicable
- When EPO is not stated on the card it very difficult to distinguish, so usually you need to call the insurance to verify

Workers' Compensation Information

- Usually an acknowledgement letter indicating the employee's Workers' Compensation carrier and name of the claims processor is sent to the provider
- When insurance is unclear, you must call to clarify

Publicly Funded Health Insurance Plans

Different publicly funded insurance plans have different rules. It is important to understand the rules for each type of insurance. Different insurance plans also require different billing procedures. The following section defines the rules for each type of insurance and specifies where bills are usually sent.

Types of Publicly Funded Health Insurance Plans

- Medicare
- Medicaid
- Medi-Cal
- Healthy Families
- California Children's Services (CCS)
- Genetically Handicapped Persons Program (GHPP)
- County Medical Services Program (CMSP)
- Civilian Health and Medical Program of the Uniformed Services (CHAMPUS/TRICARE) Foundation

Medicare

- Few restrictions
- Federal insurance administered by the Health Care Financing Administration (HCFA), a branch of the Department of Health and Human Services
- Provides health benefits to persons:
 - Receiving Social Security, Railroad Retirement, Supplement Security Income (SSI) which covers some people with disabilities
 - With end-stage renal disease (ESRD)
 - Otherwise non-covered aged persons who elect to buy into Medicare Part B

Part A – Hospital (Inpatient) Insurance

- Eligible persons receive Medicare Part A automatically
- Deductible at the beginning of each benefit period
- A benefit period begins when a beneficiary enters a hospital and ends when at least sixty (60) consecutive days passes without inpatient hospital or skilled nursing care being provided

Part B – Medical (Outpatient) Insurance

- Enrollment in Part B is voluntary
- Recipients are responsible for:
 - A yearly deductible
 - Co-insurance payments
 - 100% of some outpatient services, including prescription medications

Part D – Prescription (Rx) Insurance

- Effective January 1, 2006
- Patient must enroll in both Medicare Parts A & B to qualify for Part D prescription coverage

Note: A patient may have Part A only, Part B only, or Parts A & B

Category	Definition
Patient Liability	Part A = Deductible per “benefit period” Part B = yearly deductible and co-insurance
Classification of Providers	Any licensed provider enrolled with Medicare
Required Documentation	None required for most services
Send Claim To	Medicare (fiscal intermediary contracted to administer Medicare claims)

Other Options for Medicare Patients

Even with coverage under both Medicare Parts A and B, some Medicare recipients may incur charges beyond what they can realistically afford. To avoid this situation, Medicare recipients have two additional options.

Other Medicare Options:

- Purchase “**Medigap**” supplemental insurance from a commercial insurance company
 - These supplemental plans are either PPO plans or Indemnity plans and cover some or all charges not covered by Medicare. Example: Rx drugs
- Assign Medicare benefits to an HMO Medicare Advantage plan
 - HMO takes responsibility for the recipient’s health care
 - Recipient must follow HMO rules
 - **Advantage** – HMO covers more services at a higher rate than Medicare
 - **Disadvantage** – Many Medicare patients have difficulty adapting to the HMO regulations
 - Assignment of benefits is voluntary and may be reversed

Website Address

<http://www.medicare.gov>

Medicaid

- Jointly funded cooperative venture between the Federal and State governments
- Goal is to provide health care to some people with low income
- Eligibility for benefits is granted on a monthly basis
- Called Medi-Cal in California
- Due to broad federal guidelines, each state:
 - Establishes its own eligibility guidelines
 - Determines the type, amount, duration and scope of services
 - Sets the rate of payment for services
 - Administers its own program

In addition to reporting a low income, the following general guidelines indicate those most likely to be eligible for Medicaid benefits.

- Under 21 years old or over 65 years old
- Families with minor children who have financial support from only one parent
- Pregnant women
- Recipients of SSI

Category	Definition
Patient Liability	Usually none although differs from state to state
Classification of Providers	Various
Required Documentation	Must call to confirm any authorization requirements
Send Claim To	Medicaid for the appropriate state
Other Rules	Monthly eligibility – must call to verify eligibility

Website Address

<http://www.hcfa.gov/medicaid/medicaid.htm>

Medi-Cal

- California's version of Medicaid
- Administered by each county
- Prospective recipients must apply in his or her county of residence
- Medi-Cal beneficiaries receive a plastic Benefits Identification Card (BIC)

Medi-Cal Benefits

- Medi-Cal Fee for Service
- Medi-Cal Managed Care
- Patient may also have a Share-of-Cost (SOC)

Checking Medi-Cal Eligibility

IMPORTANT – Medi-Cal eligibility must be checked at every visit.



- Eligibility check details:
 - Is the patient eligible for Medi-Cal benefits in the current month
 - Does the patient have a SOC
 - Does the patient have another insurance in addition to Medi-Cal
 - Does the patient have Medi-Cal Managed Care
 - Is Medi-Cal coverage restricted to certain services (emergency, pregnancy)
 - A unique eligibility verification confirmation number (EVC#) is generated

Medi-Cal Fee for Service

- Traditional Medi-Cal
- Recipient can see any provider who accepts Medi-Cal
- Provider is reimbursed according to the service

Category	Definition
Patient Liability	No patient liability – unless the patient has a SOC
Classification of Providers	Any licensed provider who bills Medi-Cal
Required Documentation	Authorization called a Treatment Authorization Request (TAR) may be necessary for some costly or non-routine outpatient procedures
Send Claim To	Medi-Cal (fiscal intermediary)
Other Rules	Much check eligibility at every visit

Medi-Cal Managed Care

- In many California counties some or all of the Medi-Cal recipients have been moved into managed care programs
- Managed Medi-Cal works just like an HMO
- Patients must choose a PCP and must have a referral or an authorization for specialty care

The Medi-Cal Managed Care insurances are explained beginning on the next page.

County Organized Health Systems (COHS)

Category	Definition
Patient Liability	Usually none – unless the patient has a SOC
Classification of Providers	<ul style="list-style-type: none"> ▪ PCP for any medical problem ▪ Most care received from providers within the county
Required Documentation	Must have an authorization to be seen at UCSF
Send Claim To	Managed care insurance organization
Other Rules	Much check eligibility at every visit

Two Plan Model

Category	Definition
Patient Liability	Usually none – unless the patient has a SOC
Classification of Providers	<p>PCP for any medical problem</p> <p>PCP refers/authorized for ancillary and specialty services, usually within the PMG</p>
Required Documentation	<p>Referral for specialty services within PMG</p> <p>Authorizations for high dollar procedures and any services outside PMG</p> <p>Authorizations are obtained at the request of the PCP from the PMG and/or insurance company</p>
Send Claim To	PMG or insurance company
Other Rules	Much check eligibility at every visit

Medi-Cal Share of Cost (SOC)

What it is and who it affects:

- Medi-Cal recipients with resources above Medi-Cal's determined monthly maintenance needs
- Acts like a monthly deductible
- In any month the patient receives medical services, he or she has to pay for all services until the total cost is greater than the patient's SOC
- Expenses above the patient's SOC are covered by:
 - Medi-Cal if the patient has Fee-for-Service coverage

OR

- Medical group or insurance organization if the patient has managed care coverage

Category	Definition
Patient Liability	Monthly SOC
Classification of Providers	Any licensed provider who bills Medi-Cal
Required Documentation	Authorization called a Treatment Authorization Request (TAR) may be necessary for some costly or non-routine outpatient procedures
Send Claim To	Medi-Cal (fiscal intermediary) only after the patient's SOC has been paid for that month
Other Rules	Much check eligibility at every visit

Website Address

<http://www.medi-cal.ca.gov>

Healthy Families

- Provides low cost insurance for children and teens up to the age of 19
- Offers health, dental and vision coverage to children who meet the program rules and do not qualify for free Medi-Cal
- Administered by each county
- Twelve months of coverage as long as monthly premium is paid
- Each member can choose his or her own health plan
- A child can have both CCS and Healthy Families
- Members may have a co-payment, usually \$5.00, for most services

Category	Definition
Patient Liability	<ul style="list-style-type: none">▪ Monthly premium▪ Copayment
Classification of Providers	PCP
Required Documentation	Authorization for specialty services within in the health plan or outside the health plan

Website Address

<http://www.healthyfamilies.ca.gov>

California Children's Services (CCS)

- Provides specialty care to physically disabled children with certain specific diagnoses
- Uses federal, state and county funds
- Administered at the county level
- Any child with a CCS eligible diagnosis is eligible for the program if his or her family cannot afford to pay the full cost of treatment
- CCS is a type of managed care
- Patients must have authorization for services
- A Service Authorization Request (SAR) may be required for certain services or procedures
- In most cases, a doctor is selected to coordinate the patient's health care
- The program only covers services related to eligible diagnoses. It does not cover all health care needs

Category	Definition
Patient Liability	Usually none for services related to a qualifying diagnosis
Classification of Providers	Any licensed provider who bills CCS
Required Documentation	Authorization is required for services
Send Claim To	CCS for the appropriate county

Website Address

<http://www.dhs.cahwnet.gov/pcf/cms/html/CCS.htm>

Genetically Handicapped Persons Program (GHPP)

- Provides specialty care to physically disabled adults with certain specific diagnoses
- Administered by the State of California Department of Health Services
- Any adult with a GHPP eligible diagnosis who is unable to pay the full cost of treatment is eligible for the program
- GHPP is a type of managed care
- Patients must have authorization for services
- The program only covers services related to eligible diagnoses. It does not cover all health care needs

Category	Definition
Patient Liability	Usually none for services related to a qualifying diagnosis
Classification of Providers	Any licensed provider who bills GHPP
Required Documentation	Authorization is required for services
Send Claim To	GHPP

Website Address

<http://www.dhs.cahwnet.gov/pcfh/cms/html/ghpp.htm>

Medically Indigent Adult Program (MIA)

- Program covers adults with little or no resources who do not qualify for any other government programs
- A patient participating in the MIA program must seek services at a designated facility in his her county of residence
- An MIA patient **must** have an authorization for all services received at UCSF

Category	Definition
Patient Liability	Usually none or a very small amount
Classification of Providers	Most care is received at a county hospital
Required Documentation	Authorization for all services at UCSF
Send Claim To	The MIA program for the appropriate county facility

County Medical Services Program (CMSP)

- In counties with populations of 300,000 persons or less, care for MIA patients is administered by the Department of County Medical Services Program (CMSP)
- Functionally CMSP is similar to Fee-for-Service Medi-Cal
- A patient's eligibility for CMSP coverage is determined by each county
- CMSP recipients:
 - Are issued a BIC identical to a Medi-Cal recipient's BIC
 - May have a Share of Cost (SOC) and/or co-pay requirements
 - May seek medical services from any Medi-Cal approved provider throughout California

Category	Definition
Patient Liability	No patient liability – unless the patient has a SOC
Classification of Providers	Any licensed provider who bills Medi-Cal
Required Documentation	Authorization called a Treatment Authorization Request (TAR) may be necessary for some costly or non-routine outpatient procedures
Send Claim To	CMSP
Other Rules	Much check eligibility at every visit

Website Address

<http://www.dhs.cahwnet.gov/cmosp.htm>

Civilian Health and Medical Program of the Uniformed Services (CHAMPUS/TRICARE)

- Health insurance for individuals affiliated with the Department of Defense, including active and retired military personnel and dependents of military personnel
- In California and Hawaii this program is administered by Foundation Health Federal Services
- There are four different types of TRICARE coverage:
 - TRICARE Prime
 - TRICARE Extra
 - TRICARE Standard
 - TRICARE for Life

TRICARE Extra vs. TRICARE Standard

Patients who see pre-established Tricare providers have a 5% lower co-insurance

TRICARE Prime

- Two-tier Point of Service plan
- Patients select a primary care provider a Primary Care Manger (PCM)
- **Tier 1 functions like an HMO plan:**
 - All care provided by someone other than the patient's PCM must authorized by the patient's PCM
 - TRICARE does not always require a written authorization form, verbal authorizations must be obtained
 - Patient is responsible for copayments
- **Tier 2 functions like an Indemnity plan:**
 - The patient may self-refer to specialists
 - The patient is responsible for a deductible and 50% coinsurance payments

Category	Definition
Patient Liability	<u>Tier 1</u> = Copay <u>Tier 2</u> = yearly deductible and co-insurance for each service
Classification of Providers	<u>Tier 1</u> = PCM <u>Tier 2</u> = Any licensed provider
Required Documentation	<u>Tier 1</u> = <ul style="list-style-type: none"> ▪ Referral/Authorization for ancillary and specialty services ▪ Authorizations are obtained at the request of the PCM from CHAMPUS ▪ Authorizations are obtained at the request of the PCP from the PMG and/or insurance company ▪ Need pre-approval for inpatient services <u>Tier 2</u> = <ul style="list-style-type: none"> ▪ May need authorization for costly outpatient procedures ▪ May need pre-approval for inpatient services
Send Claim To	<u>Tier 1</u> = Foundation/CHAMPUS

TRICARE Extra/TRICARE Standard

- Works like a PPO plan
- TRICARE Extra refers to coverage when the provider is a network provider
- UCSF providers are network providers
- TRICARE Standard refers to coverage when the provider is out-of-network
- TRICARE is a Fee-for-Service plan

Category	Definition
Patient Liability	<ul style="list-style-type: none">▪ Yearly deductible – lower if seeing a network provider▪ Co-insurance for each service – lower if seeing a network provider
Classification of Providers	<ul style="list-style-type: none">▪ Network providers = TRICARE Extra (UCSF is contracted)▪ Out-of-Network providers = TRICARE Standard
Required Documentation	<ul style="list-style-type: none">▪ Authorization is required for some outpatient procedures▪ May need pre-approval for inpatient services
Send Claim To	Check CHAMPUS ID card or call phone number on card

Website Address

<http://www.tricare.osd.mil>

What to Look For on Publicly Funded Health Insurance Cards

Publicly Funded health insurance cards provide important information regarding a patient's type of health insurance. This section explains what details on an insurance card indicate the type of insurance plan.

Medicare Card

- The Card states:
 - Medicare Health Insurance
 - The Social Security Act or Railroad Retirement
 - If the patient is entitled to Part A only, Part B only, or both Part A and Part B
 - The effective date(s)

Medicare Advantage Card

- The Card may list:
 - A PCP and/or a PMG
 - A copay
- The card may mention Medicare in conjunction with HMO rules
- Some of the more common Medicare Advantage plans are:
 - Aetna Senior Choice
 - Blue Shield "Shield 65"
 - Cigna Senior
 - Health Net Seniority Plus
 - PacifiCare Secure Horizons
 - Prudential Senior Care (Prucare)

Medicaid Card

- The card states Medicaid
- The card states the state of residence of the patient

Medi-Cal Card

- The card does not state Medi-Cal but displays the State of California seal
- The card states the patient's name, ID number, birth date, gender and Medi-Cal effective date

Medi-Cal Managed Risk Card

- Language states Medi-Cal and HMO rules
- May state a PMG or PCP
- The two Medi-Cal Managed Risk plans in San Francisco are Blue Cross and San Francisco Health Plan

CCS Card

- The card states California Children's Services and the address of the County Health Department
- County in which the patient resides
- Card may indicate that the patient's has both CCS and Medi-Cal

GHPP Card

- The card states GHPP

MIA Program

- Patient does not have a card but needs an authorization

CMSP Card

- CMSP recipients are issued a BIC identical to the one Medi-Cal recipients receive

CHAMPUS Card

- CHAMPUS/TRICARE Prime or Extra – Foundation Health Federal Services, Inc.
- A PCP may be listed – referred to a Primary Care Manager (PCM)

Other Important Card Information

In addition to the type of insurance, other important information may also be included on an insurance card. This section lists the other types of information contained on a patient's insurance card.

Identification Number (ID Number)

- **REQUIRED FOR BILLING**
- Used by insurance company to identify subscriber/member
- Sometimes letters and numbers precede or follow the subscriber's SSN
- Sometimes a unique number is used for identification purposes
- ID numbers can also be called a:
 - Certificate number
 - Policy number
- Some insurance cards list the ID number as the most prominent number on the card

Subscriber's Name

- **REQUIRED FOR BILLING**
- Person who obtains the health insurance through employment or by purchasing it or by qualifying for a publicly funded program

Member's Name

- Person who is covered by the insurance
- Not always the same person as the subscriber (For example: a minor child, the parent is the subscriber and the child is the member)

Note: Be careful when looking at an insurance card to determine what name is listed. Sometimes the subscriber's name is listed and sometimes the individual member's name is listed. Sometimes both names are listed.

Claims Mailing Address

- **REQUIRED FOR BILLING**
- Check the claims mailing address carefully to determine if it is the appropriate address for the bills from your department (technical fees versus professional fees)
- Sometimes it is necessary to call to obtain the correct claims mailing address

Effective Date

- Date the insurance coverage began
- Helpful in determining if the insurance is current

Group Number

- **REQUIRED FOR BILLING**
- Refers to a group of insured people receiving the same benefits
- Often related to a group of employees from one company
- When provided it is an important billing criterion

Telephone Numbers

- Claims/Eligibility telephone numbers are used to inquire about claims status or insurance eligibility
- Authorization/Utilization Review telephone numbers are used to obtain or clarify authorization information as well as pre-approval and concurrent review status

Coordination of Benefits (COB)

When a patient is covered by more than one insurance it is called Coordination of Benefits (COB). When a patient has COB it is necessary to know which insurance is billed as primary and any subsequent billing order. There are rules that determine the priority of billing insurances (payors).

Type of Insurance		Bill as Primary	Bill as Secondary
Two commercial insurance only (adult patient)		Patient's insurance	Spouse's insurance
Two commercial insurances only (minor patient)	Parents married or living together – Birth Date rule applies ❶	Parent with earlier birth month	Parent with later birth month
	Parents divorced, separated, not married/sharing residence ❷	Parent with primary custody	Parent without primary custody
Medicare and Medi-Cal		Medicare	Medi-Cal
Medicare and commercial insurance ❸	When commercial insurance is through patient's or spouse's current employer	Commercial	Medicare
	When commercial insurance is not through patient's or spouse's current employer	Medicare	Commercial
Commercial and Medi-Cal		Commercial	Med-cal
CCS and Medi-Cal Fee-for-Service ❹		CCS (county)/Medi-Cal	
CCS and Medi-Cal Managed Care ❺		CCS (county)/M-Cal	Medi-Cal Mngd Care
GHPP and Medicare		Medicare	GHPP

1. If both parents are born in the same month, insurance of the parent with earliest date of birth is primary. If both parents are born in the same month and on the same day, parent covering the child the longest is primary.
2. A court decree specifically stating one parent has primary responsibility to insure the child overrides custody and Birth Date rule.
3. Medicare Secondary Payor rules require the group health plan to pay all covered benefits before Medicare when:
 - Those entitled to Medicare due to age have group health plan coverage with an employer with more than 20 employees.
 - Those entitled to Medicare due to disability have group health plan coverage with an employer with more than 100 employees.
4. All claims are sent first to CCS but Medi-Cal Fee-for-Service pays as primary.
5. IDX Flowcast cannot accommodate a combined CCS and Medi-Cal Managed Care code. Load each insurance separately. All claims are first sent to CCS but Medi-Cal Managed Care pays primary.

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