# Insurance Registration INS100

## Centricity® Business 4.3

### Manage Insurance Information

<table>
<thead>
<tr>
<th>#</th>
<th>FSC</th>
<th>CONTRACT #</th>
<th>GROUP</th>
<th>R SUBSCRIBER</th>
<th>CO-PAY</th>
<th>EFF DATE</th>
</tr>
</thead>
</table>

---

**Add** | **Copy** | **Edit** | **Insert** | **View Audit Trail** | **View** |

**Delete** | **Change Order** | **Show/Cr Deleted** | **View** |

---

[Actions] [OK] [Cancel]

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MSU HealthTeam Training and Education (M-F 8a – 5p)
Melody Frye  517-432-0898  melody.frye@ht.msu.edu

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MSU HealthTeam 6/16/2009
Insurance Registration

Overview

Insurance registration captures the information needed to bill (produce claim forms) and be paid for services provided to a patient. Insurance information is obtained from patients or other entities (hospital or another physician office) and verified through a web based verification system prior to the date of service. Verification of insurance coverage with the insurance carrier and accurate entry of insurance information into Centricity Business eliminates claim denials, ensures timely payments, and contributes to patient satisfaction.

Objectives

1. Provide an overview of medical insurance and terminology
2. Explain the Centricity Business “FSC” set up (Financial Status Classification) and how it is used to enter and manage insurance information in the system.
3. Demonstrate how to use action codes and complete fields when entering insurance.
4. Read and interpret insurance cards to determine type of coverage and provider participation.
5. Prioritize multiple insurances in the “FSC” List
6. Introduce the HealthTeam Insurance “FSC” Grid and how to use it.
7. Demonstrate the use of Insurance Web Tools to verify patients’ eligibility and benefits.
## System Functionality

<table>
<thead>
<tr>
<th>Critical Information</th>
<th>What it Does</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blue field</td>
<td>Identifies the field the cursor is in</td>
</tr>
<tr>
<td>Yellow field</td>
<td>Indicates a required field.</td>
</tr>
<tr>
<td>Action Code</td>
<td>Allows a specific action to occur through a pop up box or movement to another screen</td>
</tr>
<tr>
<td>Delete</td>
<td>Erases</td>
</tr>
<tr>
<td>@P</td>
<td>Copies Patient Address Information to insurance subscriber address field</td>
</tr>
<tr>
<td>F11</td>
<td>Refreshes the screen to correct display</td>
</tr>
<tr>
<td>Logout</td>
<td>Exits the system</td>
</tr>
<tr>
<td>OK/Save</td>
<td>Files information entered (Saves it)</td>
</tr>
<tr>
<td>Tab</td>
<td>Moves through the fields. <em>Exclusively use tab to move to the next appropriate field.</em></td>
</tr>
<tr>
<td></td>
<td>The building blocks of the system. Dictionary entries can be pulled into screens and fields</td>
</tr>
</tbody>
</table>
Glossary of Insurance Terms

**Annual maximum benefit amount** - The maximum dollar amount that limits the total amount a plan must pay for all healthcare services provided to a subscriber in a year.

**Assignment Of Benefits** - The legal transfer to authorize payments from an insurance carrier to another person (patient authorizes payments to go directly to the provider).

**Claim** - An itemized statement of healthcare services and their costs provided by a hospital, physician's office, or other provider facility. Claims are submitted to the insurer or managed care plan by either the plan member or the provider for payment of the costs incurred.

**Claim form** - An application for payment of benefits under a health plan.

**Coinsurance** - Some insurance coverage requires you to pay a percentage of the cost of covered medical services, usually 20-30 percent. For example, you pay 20 percent of the cost, and your insurance pays 80 percent of the cost. Your portion of the cost is the coinsurance.

**Co-payment** - A flat fee or percentage amount for specified medical services required by some insurers. For example, you pay a $10 co-payment for a doctor visit or a $50 co-payment for a hospital stay.

**Deductible** - The amount you must pay each year for your medical expenses before your insurance policy starts paying. Deductibles are common in fee-for-service coverage and PPOs.

**Fee-for-Service (FFS)** - Also known as indemnity insurance, FFS is a type of health coverage that typically allows you to go to any doctor or provider. Your insurance company will reimburse your provider for each covered service provided. Deductibles and coinsurance usually apply in FFS coverage.

**Fee schedule** - The fee determined by an MCO to be acceptable for a procedure or service, which the physician agrees to accept as payment in full. Also known as a fee allowance, fee maximum, or capped fee.

**Managed care organization (MCO)** - Any entity that utilizes certain concepts or techniques to manage the accessibility, cost, and quality of healthcare. Also known as a managed care plan.

**Medicaid** - A jointly funded federal and state program that provides hospital expense and medical expense coverage to the low-income population and certain aged and disabled individuals.

**Medicare** - A federal government hospital expense and medical expense insurance plan primarily for elderly and disabled persons. See also Medicare Part A, Medicare Part B, and Medicare Part C.
Medicare Part A - The part of Medicare that provides basic hospital insurance coverage automatically for most eligible persons. See also Medicare.

Medicare Part B - A voluntary program that is part of Medicare and provides benefits to cover the costs of physicians' services. See also Medicare.

Medicare Part C - The part of Medicare that expands the list of different types of entities allowed to offer health plans to Medicare beneficiaries. Also known as Medicare+Choice. See also Medicare.

Medicare supplement - A private medical expense insurance plan that supplements Medicare coverage. Also known as a Medigap policy.

Network - The group of physicians, hospitals, and other medical care providers that a specific managed care plan has contracted with to deliver medical services to its members.

Non-profit Indemnity Insurers - Non-profit indemnity insurers employ managed care strategies but offer a more traditional approach to coverage than HMOs. Non-profit indemnity insurers reimburse policyholders, physicians and hospitals. Non-profit policyholders are subject to deductibles and out-of-pocket costs that are considerably higher than those required by HMOs unless they use a preferred provider network.

*Participating Provider - A health care provider (e.g., doctor, psychologist, hospital) who agrees to accept the terms, conditions and allowable payments of an insurer.

Physician-hospital organization (PHO) - A joint venture between a hospital and many or all of its admitting physicians whose primary purpose is contract negotiations with MCOs and marketing.

Point of Service (POS) Plan - A type of managed care coverage that allows members to choose to receive services either from participating HMO providers or from providers outside the HMO’s network. Members pay less for in-network care. For out-of-network care, members usually pay a deductible and coinsurance.

Preferred Provider Organization (PPO) - A type of managed care coverage based on a network of doctors and hospitals that provides care to an enrolled population at a prearranged discounted rate. PPO members usually pay more when they receive care outside the PPO network.

Precertification - Authorization to deliver healthcare service that is issued before any service is rendered.

Preferred provider arrangement (PPA) - As defined in state laws, a contract between a healthcare insurer and a healthcare provider or group of providers who agree to provide services to persons covered under the contract. Examples include preferred provider organizations (PPOs) and exclusive provider organizations (EPOs).
Primary care - General medical care that is provided directly to a patient without referral from another physician. It is focused on preventative care and the treatment of routine injuries and illnesses.

Primary Care Provider (PCP) - An internist, pediatrician, family physician, general practitioner, or in some instances an obstetrician/gynecologist. If you are enrolled in an HMO, you usually must choose a PCP from a list of participating providers. The PCP coordinates your care and makes referrals to specialists as needed.

Prior authorization - In the context of a pharmacy benefit management (PBM) plan, a program that requires physicians to obtain certification of medical necessity prior to drug dispensing. Also known as a medical-necessity review.

Referral - Authorization from your primary care physician or health insurer to see a specialist or receive a special test or procedure. HMOs often require that you obtain a referral for most specialty care. It is important to know what your health insurer’s rules and procedures are for referrals.

Self-Insured Health Plan - In this type of plan, an employer will pay for employees’ health care costs out of a fund that the company has set aside for medical expenses. Employers may contract with an outside organization, often an insurance company, to administer the plan. Under a federal statute known as ERISA, the U.S. Department of Labor has authority over self-insured employer health plans. Therefore, New York’s consumer protection and insurance laws do not apply.

Specialist - A doctor who has been specially trained in and practices a specific type of medicine other than primary care (e.g., cardiologists, dermatologists, gastroenterologists). If you are enrolled in an HMO, you usually will need a referral from your primary care physician to see a specialist.

Third party administrator (TPA) - A company that provides administrative services to Managed Care Organizations or self-funded health plans.

TRICARE - A healthcare plan, available to more than 6 million military personnel and their families, which is administered by private contractors who are selected for participation through a competitive procurement process. TRICARE offers members three plan options - TRICARE Prime (a capitated HMO with nominal premiums and co-payments), TRICARE Extra (a PPO with standard CHAMPUS deductibles), and TRICARE Standard (the current fee-for-service CHAMPUS plan with provider choice and no premiums). See also Civilian Health and Medical Program of the Uniformed Services.

Workers’ compensation - A state-mandated insurance program that provides benefits for healthcare costs and lost wages to qualified employees and their dependents if an employee suffers a work-related injury or disease.
PART 1 – ENTERING INSURANCE INFORMATION INTO CENTRICITY BUSINESS

The building blocks for Centricity Business insurance registration include an Insurance Dictionary, a Financial Status Classification Dictionary and an Insurance Table that stores a patient’s insurance. This table and the dictionaries dictate the order of insurance billing, what type of claim is generated and where the claim is sent.

Insurance registration is performed through accessing the insurance table and entering the insurance name with all related information in the appropriate fields. Action codes allow you to perform different actions such as adding, editing and deleting insurances.

Prior to entering insurance into the system, the insurance card(s) must be reviewed and the appropriate Registration FSC(s) identified for the insurance(s) presented by the patient. The correct order or “priority” is also determined for entry into the system. There are two tools that will help determine the appropriate FSC(s) for the insurance(s) and the listing order. The FSC Grid is a list of insurances product names and the FSC that corresponds with the product (see separate handout). The second tool is a FSC Prioritization List document that provides guidance for determining the billing order for the insurances (see page 24).

“What Is A FSC” - See Page 25

Screen shot of a completed insurance table.

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Getting Started

Just like demographic registration there are different places in Centricity Business where insurance registration can be accessed.

- Patient Services – Insurance Link
- Scheduler – New Appointment Screen
- Scheduler – Provider Schedules, Appointment Overview Screen
- Appointment Manager – Clinic/Provider Appointment List under Action “Registration”
- Appointment Manager – Appointment Overview Screen under “Registration Insurance or Action “Insurance Detail

Accessing Insurance through Patient Services

To access insurance registration click on Insurance. The Insurance Table will display.
Insurance Table

Select a **FSC Action Code option** by clicking on the letter or underlined verbiage that corresponds to the desired action. The above screen does not list any insurance so certain actions codes cannot be used such as edit insurance.

**Action Code options:**

A – Add a new insurance to the insurance table
C – Copy insurance information of an existing insurance (FSC) in the table to another FSC
D – Delete an existing insurance in the insurance table
E – Edit an existing insurance in the insurance table
H – Change the order of the insurances listed in the table
I – Insert insurance into the list of insurances
S – Show Deleted insurance
T - View the audit trail
V - View insurance displayed in the active insurance table

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Adding insurance in Registration

Action Code A - Add

Click on the ADD action code
The following window will appear

Add Financial Class:

Using the FSC Grid (see hand out), identify the correct FSC for the insurance to be enter. The FSC can be entered by typing the FSC number, the mnemonic, the first few letters of the FSC name or by clicking on the search button.

Excerpt from FSC Grid showing Insurance (Product Name), FSC Mnemonic and FSC Number.

<table>
<thead>
<tr>
<th>Product Name</th>
<th>Mnemonic</th>
<th>Numeric FSC Selection</th>
<th>Additional Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicaid</td>
<td>MA</td>
<td>101</td>
<td>$200 co-pay pt’s 21 yrs and older</td>
</tr>
<tr>
<td>Medicaid HMO Medicaid Comprehensive Health</td>
<td>MCH</td>
<td>611</td>
<td>NonPar - Should not see patients with Medicaid Managed Care coverage except for McLaren Health Plan (FSC318), PHP FamilyCara (FSC 66)</td>
</tr>
<tr>
<td>Medicare</td>
<td>M</td>
<td>81</td>
<td>FAR</td>
</tr>
</tbody>
</table>

FSC Follow-Up Questions

Your screen will display fields that need to be completed so a claim can be submitted to the insurance carrier. Financial Classes may have different fields (follow-up questions). However, the format of adding insurance information is the same. The questions have been set up according to the information that the insurance carrier requires to process a claim for services provided.

The following are examples of 3 different FSC’s (insurances) and the fields (follow-up questions) connected to those FSC’s. Let’s enter the following insurances into a patient’s insurance table.
Medicaid

Insurance: MEDICAID[Field 1 of 17]

Patient: MOUSE,Minnie
555 DISNEY STREET
BATTLE CREEK, MI 49017

DOB: 03/06/2008

Verified By:
Date Verified w Ins Carrier:
ID NUMBER:
CHILDREN’S SPECIAL H.C. SERVICES:
COV TYPE:
OV Copy:
Ins. Co. Telephone:
RELATIONSHIP TO CARDHOLDER:
CARDHOLDER’S NAME:
First Line of Subscriber Address:
Second Line of Subscriber Address:
City, State:
Zip Code:

Subscriber Box:
Subscriber’s birthday:
Effective Date:
Expiration Date:

OK Cancel

Medicaid Card with 10 digit ID number
**Medicaid FSC Fields**

<table>
<thead>
<tr>
<th>Field Name</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Verified By:</td>
<td>Enter the last name, first name of person that verified information with insurance company or agency.</td>
</tr>
<tr>
<td>Date Verified w Ins:</td>
<td>Enter date of verification</td>
</tr>
<tr>
<td>ID Number:</td>
<td>Enter the Medicaid 10 digit ID number as displayed on card.</td>
</tr>
<tr>
<td>Childrens Spec HC Serv:</td>
<td>If a child presenting for care is covered under Children’s Special Health Care Services, enter “Y”.</td>
</tr>
<tr>
<td>Cov Type:</td>
<td>Enter CSHCS if the cardholder is covered under CSHCS.</td>
</tr>
<tr>
<td>OV Copay:</td>
<td>Enter the co-pay amount if the cardholder is 18 or over.</td>
</tr>
<tr>
<td>Ins Co Telephone:</td>
<td>Can leave blank</td>
</tr>
<tr>
<td>Relationship to Cardholder:</td>
<td>Enter S for Self. Medicaid and CSHCS recipients are always the cardholders.</td>
</tr>
<tr>
<td>Cardholder’s Name:</td>
<td>@P will complete all the fields pertaining to the patient’s address, sex and birthday.</td>
</tr>
<tr>
<td>Effective Date:</td>
<td>Enter the date the patient was enrolled in the program. If unknown leave blank.</td>
</tr>
<tr>
<td>Expiration Date:</td>
<td>Enter the date the patient was disenrolled. If unknown leave blank. When a patient is dis-enrolled or their insurance expires, the FSC is placed in the Deleted Table. She Action Code “D” for deleting insurance.</td>
</tr>
</tbody>
</table>
**Medicare**

Insurance: MEDICARE [Field 1 of 16]

- **Patient:** MOUSZ, MINNIE
- **Address:** 555 DISNEY STREET, BATTLE CREEK, MI
- **MRN:** 4802072
- **FSC:** M
- **SSN:** 000-00-0008
- **DOB:** 03/06/2008

- **Verified By:**
- **Date Verified w Ins Carrier:**
- **Relationship to Subscriber:**
- **Subscriber Name:**
- **First Line of Subscriber Address:**
- **Second Line of Subscriber Address:**
- **City, State:**
- **Zip Code:**
- **Subscriber Sex:**
- **Subscriber’s birthday:**
- **PART D PHARMACY PLAN NAME:**
- **PT’S PHARMACY PLAN ID #:**

- **PART D PHARMACY TEL #:**
- **MEDICARE EFFECTIVE DATE:**
- **Expiration Date:**

OK | Cancel

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### Medicare FSC Fields

<table>
<thead>
<tr>
<th>Field Name</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Verified By:</td>
<td>Enter the last name, first name of person that verified information with insurance company or agency.</td>
</tr>
<tr>
<td>Date Verified w Ins:</td>
<td>Enter date of verification</td>
</tr>
<tr>
<td>Medicare Number:</td>
<td>Enter the Patient’s 9 digit plus 1 alpha character ID number</td>
</tr>
<tr>
<td>Relationship to Subscriber:</td>
<td>Enter S for Self. Medicaid and CSHCS recipients are always the cardholders.</td>
</tr>
<tr>
<td>Subscriber’s Name:</td>
<td>@P will complete all the fields pertaining to the patient’s address, sex and birthday.</td>
</tr>
<tr>
<td>Part D Pharmacy Plan Name:</td>
<td>Name of the Pharmacy Insurance Company</td>
</tr>
<tr>
<td>Pt’s Pharmacy Plan ID #:</td>
<td>Enter the identification number for the Pharmacy Plan</td>
</tr>
<tr>
<td>Part D Pharmacy Tel #:</td>
<td>Enter 10 digit telephone number of the Pharmacy Plan Name</td>
</tr>
<tr>
<td>Medicare Effective Date:</td>
<td>Enter the effective date of the Medicare coverage from the card.</td>
</tr>
<tr>
<td>Expiration Date:</td>
<td>Enter the expiration date if known. Medicare coverage usually won’t have an expiration date.</td>
</tr>
</tbody>
</table>
Editing Insurance Information

Action Code E - Edit a FSC for a patient:

Highlight the FSC you wish to edit

<table>
<thead>
<tr>
<th>#</th>
<th>FSC</th>
<th>CONTRACT #*</th>
<th>GROUP#</th>
<th>R SUBSCRIBER</th>
<th>CO-PAY EFF DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>81</td>
<td>M</td>
<td>987654321A*</td>
<td>*</td>
<td>1 MOUSE,Minnie</td>
<td>06/31/2009</td>
</tr>
<tr>
<td>1</td>
<td>M</td>
<td>1234567890*</td>
<td>*</td>
<td>1 MOUSE,Minnie</td>
<td>01/01/2009</td>
</tr>
</tbody>
</table>

CSHCS

Click E to edit the FSC follow up questions.

Click in the field to be edited or down arrow if field does not display.
**Deleting Insurance**  
**Action Code D - Delete:**

Highlight the FSC you wish to edit

<table>
<thead>
<tr>
<th>#</th>
<th>FSC</th>
<th>CONTRACT #*</th>
<th>GROUP# R SUBSCRIBER</th>
<th>CO-PAY EFF DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>01</td>
<td>M</td>
<td>987654321A*</td>
<td>1 MOUSE,MINNIE</td>
<td>08/31/2009</td>
</tr>
<tr>
<td>02</td>
<td>MA</td>
<td>1234567890*</td>
<td>1 MOUSE,MINNIE</td>
<td>01/01/2009</td>
</tr>
</tbody>
</table>

Click D to Delete the FSC

The following pop up will display

**Centricity® Business**

Do you want to permanently delete this FSC and the FSC follow-up information?  
Answer No to delete the FSC and leave the FSC follow-up information on the system.  
Answer Yes to delete the FSC and the FSC follow-up information.

![Pop up window with options Yes, No, Cancel]

**DELETE ALL FOLLOW-UP INFORMATION FOR THIS FSC? NO—>**

**Reason for saving terminated / deleted insurance information:**

1. All claims filed to the insurance may not have been paid  
2. Insurance may need to be contacted to have old claims paid  
3. A claim may need to be re-filed to the insurance  
4. The patient may only be terminated with the insurance intermittently
Changing the Order of Multiple Insurances
Action Code H – Change Order

FSCs’ listing order affect the order in which the system bills the insurances. For example, An insurance listed first will be billed first, while the insurance listed with second will be billed next, and so on. Insurance Rules dictate the order for billing multiple insurances (see Insurance Prioritization (page )).

To change the order of a FSC:
Highlight the FSC to be moved.

Click H – Change Order

Click D to move insurance down followed by OK

OR

Click U to move the insurance up in priority

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Displaying Field Detail for an Insurance Listed in the Insurance Table

Action Code V - View a patient’s FSC

Highlight the FSC you want to view
Click V to View the FSC

Displaying a Deleted Financial Status Classification

Action Code S – Show/Clear Deleted FSCs

Click on S

If the patient has any previous insurance information that had been deleted and stored in the deleted insurance table, the deleted insurance information will display.

To clear the deleted FSC display, click on S again.
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Copying Insurance Information From an Existing FSC to Another FSC

Action Code C - Copy

This action code will copy fields from an insurance in the insurance table to a newly created FSC.

Highlight the Insurance to be Copied From

<table>
<thead>
<tr>
<th>#</th>
<th>FSC</th>
<th>CONTRACT #*</th>
<th>GROUP #</th>
<th>SUBSCRIBER</th>
<th>CO-PAY</th>
<th>EFF DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>M</td>
<td>987654321A*</td>
<td>&quot;</td>
<td>MOUSE,MINNIE</td>
<td></td>
<td>08/31/2009</td>
</tr>
<tr>
<td>2</td>
<td>MA</td>
<td>1234567890*</td>
<td>&quot;</td>
<td>MOUSE,MINNIE</td>
<td>CSNCS</td>
<td>01/01/2009</td>
</tr>
</tbody>
</table>

Click on Copy

Enter the FSC to be Copies To

Entered FSC 611

Once copied, information must be reviewed and moved to different fields as necessary. Additional information may also need to be added.

NOTE: This “Copy” moved Medicaid information with 16 total fields to Medicaid HMO, 25 total fields.

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**Inserting Insurances Into The Insurance Table**

Action Code I - Insert

Highlight the insurance where you want the new insurance inserted

**Manage Insurance Information**

<table>
<thead>
<tr>
<th>#</th>
<th>FSC</th>
<th>CONTRACT #</th>
<th>GROUP*</th>
<th>R SUBSCRIBER</th>
<th>CO-PAY EFF DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>01</td>
<td>M</td>
<td>987654321A*</td>
<td>*</td>
<td>1 MOUSE,MINNIE</td>
<td>08/31/2009</td>
</tr>
<tr>
<td>21</td>
<td>BS</td>
<td>832999333*</td>
<td>53322*</td>
<td>1 MOUSE,MINNIE</td>
<td></td>
</tr>
<tr>
<td>101</td>
<td>MA</td>
<td>1234567890*</td>
<td>*</td>
<td>1 MOUSE,MINNIE</td>
<td>01/01/2009 CSCHS</td>
</tr>
</tbody>
</table>

Click on Action Code Insert

Enter the Insurance FSC to be inserted

Proceed as with Action Code A – adding insurance to the insurance table. Inserting will add the new insurance to the position you indicated in the table (it will list after the insurance highlighted).
**Viewing Previous Entries or Changes to Insurance Fields**

**Action Code T – View Audit Trail**

This action code will allow you to view the creation of, or any changes to, a FSC listed in the insurance table. It will display the field name, what was entered, the date entered and the username of the person entering the information.

Highlight the insurance you want to view

<table>
<thead>
<tr>
<th>#</th>
<th>FSC</th>
<th>CONTRACT #</th>
<th>GROUP #</th>
<th>SUBSCRIBER</th>
<th>CO-PAY</th>
<th>EFF DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>01</td>
<td>M</td>
<td>987654321A*</td>
<td>*</td>
<td>1 MOUSE, MINNIE</td>
<td></td>
<td>08/31/2009</td>
</tr>
<tr>
<td>21</td>
<td>BS</td>
<td>8329993333*</td>
<td>53322</td>
<td>1 MOUSE, MINNIE</td>
<td>CSHCS</td>
<td>01/01/2009</td>
</tr>
<tr>
<td>101</td>
<td>MA</td>
<td>1234567890*</td>
<td>*</td>
<td>1 MOUSE, MINNIE</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Click on Action Code T

The Audit Trail Screen displays the initial date of entry and changes made. Note this insurance had two pieces of information deleted on 9/25/09 by User MSUTRAIN08. CSHCS Field entry “Y” and Coverage Type field entry “CSHCS” was removed.
Adding Insurances Utilizing The Commercial Insurance Dictionary

Many Insurance Companies are loaded in a Centricity Business dictionary that houses the address, telephone number and other information for the insurance.

Click on Action code “A” to add an insurance that ties to this dictionary. We’ll add Aetna HMO. Enter FSC Number (see FSC Grid). Note: there are multiple FSC’s that pull insurance carrier names from the Commercial Ins Dictionary.

Enter insurance name in Commercial Insurance CO #1 field. A pop up will display with all dictionary entries that match.

Select Aetna HMO and click OK. Fields will populate. Note: Check the information pulled from the dictionary for correctness and complete additional fields. Click OK to file and add the insurance to the table.

Insurance Name can be overridden in the Ins. Co. Name override field.
**Printing a Face Sheet After Insurance Information Has Been Added or Edited.**

After a patient’s insurance has been added, click okay to leave the insurance table and action codes.

A pop up box will appear offering the option to print a face sheet. If no face sheet is needed, cancel. To print a face sheet follow these steps. See “Printing Face Sheet (Form #33)”.

**In Registration or Insurance you must specify Encounter Form on the Registration Document Drop Down Box and click okay**

1. In Registration Document:
   - Enter #33 in form field, click OK.
   - Clicking on Magnifying Glass will give you drop down list of forms

2. Enter Printer Device number and click OK

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Insurance (FSC) Prioritization

When a patient has one or more insurance policies, listed below are helpful hints to determine which would be the patient’s primary insurance and which would be their secondary insurance.

1. When a patient is working and has insurance through their employer, this insurance is always their primary insurance.

2. If a patient is working, has insurance through their employer and is also covered under another insurance policy through their spouse, rule #1 applies. The insurance provided to an employee is always primary. The spouse’s insurance would be secondary.

3. If a patient is eligible for Medicare and has a supplemental insurance, Medicare is always primary and the supplemental is secondary. Example: Medicare and AARP, Medicare is primary and AARP is secondary.

4. If a patient is eligible for Medicare, but is working and has insurance through their employer, the insurance through the employer is always primary and Medicare is secondary.

5. If a patient has Medicare but their spouse is working and has the patient with Medicare on their policy, the spouse’s insurance is primary over Medicare.

6. Medicaid is always secondary if a patient has another type of insurance coverage. This includes patients with Medicare, HMO, PPO, or any commercial insurance coverage. Always ask if they have any other insurance coverage.

7. To determine the primary payor for children that are covered as dependents on both parent’s policies, the birthday rule is used. The Birthday rule states whichever parent’s birthday falls first in the calendar year, assumes primary position in the payor chain.
What is a FSC (Financial Status Classification)

FSC is an acronym for Financial Status Classification. A FSC is what determines who is responsible for a charge or an invoice balance. There is a FSC dictionary that defines all FSCs and dictates how a particular FSC interacts with the system.

A FSC controls if a statement is sent to a patient or a claim is sent to an insurance company. The FSC also determines the amount of payment expected from an insurance company, how payments received will post to a patient’s account or an invoice within that account. The FSC tracks where the Health Team’s accounts receivables (all money owed to the practice) are; how much is outstanding with insurance A, with insurance B and how much is patients’ responsibility. FSCs can tell us how much of the patient outstanding accounts receivables is current, how much is in-house but past due and how much has been referred to a collection agency.

In this class a FSC equates to an insurance carrier. It determines who will pay for the services the patient will receive and the order in which the insurances will be billed. A FSC keeps track of all contracts between the HealthTeam and Insurance Companies. The FSC helps us know what insurances our physicians participate with, what the patient’s co-pay is, and whether we need authorization from the insurance carrier to see the patient.

Because the FSC is so critical in the billing process; where the charge is sent, what gets paid, how much is paid, how the payment is posted to the patient’s account, it is critical that when adding insurance to the insurance table the insurance is placed in the correct FSC and in the correct order. The “Insurance FSC Grid” and the “Insurance Prioritization” sheet provide guidance in entering a patient’s insurance information into Centricity Business.
PART 2 - PRODUCT IDENTIFICATION AND FSC PLACEMENT

Utilizing the FSC Grid and carefully reading insurance cards (front and back) is key to placing a patient's insurance(s) in the correct FSC(s). There are many variations of an insurance card design and layout depending on the insurance carrier or different products offered by one insurance carrier. The age of a patient’s insurance card can also contribute to a card’s “look”. Card designs and layouts can change from year to year for an insurance carrier or a specific carrier’s product when they offer multiple products. That being said, there are many clues on the cards that provide information to guide us in determining what kind of insurance it is, if the HealthTeam participates, and what FSC should be used to register the insurance.

Looking at a Card

There is a lot of information that can be gathered from an insurance card. Always look for the following.

- Logos or Symbols such as a suit case, a butterfly, a shield a cross
- Abbreviations or product names such as PPO, POS, or Managed Care,
- Claim Addresses
- Co-pay indicators
- Types of specific medical coverage or restrictions such as mental health, specialty versus primary, physical therapy, eye care
- Telephone Numbers such as Preauthorization, Customer Service, Provider Services
- Prescription coverage indicators such as Pharmacy Insurance Plan Name, Rx, BIN #
- Primary Care Provider Assignment
Here are some card examples