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To: County California Children Services Offices and State Children's Medical Services Regional Offices

Subject: Required Use of Health Insurance

Enclosed for your information is a revised copy of the California Children Services (CCS) requirements for using health insurance resources before using program funds. It is the CCS client's responsibility to utilize his or her private health insurance first, whether it is indemnity coverage, a health maintenance organization or a preferred provider organization, before using CCS and Medi-Cal funds. These requirements are necessary to ensure that CCS is the "payor of last resort" and to reduce program costs by shifting the liability for payment of services to the responsible third party.

If you have any questions regarding these health insurance requirements, please feel free to contact David Jimenez, CCS Program Standards and Quality Assurance Section, at (916) 654-6039.

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Children Medical Services Branch

Enclosure

CCS REQUIREMENTS FOR THE USE OF HEALTH INSURANCE
(Revised March 1994)

I. GENERAL CALIFORNIA CHILDREN SERVICES (CCS) PROGRAM POLICY RELATING TO HEALTH INSURANCE PROGRAMS

A. HEALTH INSURANCE PLANS

Definition: Health insurance is a generic term applying to all types of health insurance indemnifying or reimbursing for costs of hospital and medical care or lost income arising from an illness or injury. Included under this heading are various types of insurance such as accident insurance, disability income insurance, medical expense insurance, and accidental death and dismemberment insurance. Health insurance plans provide benefits in the form of cash payments or services. They generally require an individual or family deductible be met on an annual basis before benefits are paid. These plans usually allow the subscriber to submit claim forms directly or they may assign the claim to the provider of service for submission.

1. All entitlement to health insurance coverage must be reported at the time of application, annual renewal, and at any time that entitlement begins, ends or changes. The Health Insurance Information form (MC 2600) shall be completed by individuals with health care coverage.

2. Recipients must agree as a condition of eligibility for the CCS program to use all available health insurance prior to the use of CCS funds.

   (a) Diagnostic and treatment services require a signed application which includes the statement that the applicant agrees to use available health insurance coverage in place of CCS funds whenever possible.

   (b) A signed program services agreement authorizes CCS to verify health insurance coverage and obtain reimbursement from families receiving money from health insurance if CCS funds were expended for the same services.

   (c) A signed program services to immediately notify CCS of changes in coverage, involvement in a personal injury matter including attorney

representation and court dates, and the assignment of insurance rights.

3. A recipient must provide current health insurance coverage information to providers at the time services are delivered. This information shall include the name of the insurance carrier, policy and group numbers, and termination date if available.

4. Providers must bill health insurance before billing CCS. The CCS program by law is the payor of last resort. CCS shall assist by giving providers full information about the patient's health insurance payments or denials when billing CCS. Providers should be reminded about CCS policy prohibiting the billing of patients for CCS authorized services.

5. Recipients must reimburse the CCS program for any payment received for health care services which were paid by the CCS program if the payment is made by a legal or contractual entitlement with a health insurance plan.

B. INDEMNITY PLANS

Definition: Indemnity plans are similar to insurance policies; however, benefits are usually in the form of cash payments rather than services. The indemnity insurance contract usually defines the maximum amounts which will be paid for the covered services. In most cases, after the provider of service has billed the patient in the usual way, the insured person submits to the insurance company proof that he or she has paid the bills and is then reimbursed by the company in the amount of the covered costs. The difference between the cost of service and reimbursed amount is the liability of the insured. In some instances, the provider of service may complete the necessary forms and submit them to the insurance company directly for reimbursement and billing the patient for the costs which are not covered. Indemnity plans may require the insured to meet an annual deductible.

C. PREFERRED PROVIDER ORGANIZATIONS (PPOs)

Definition: PP0s are an arrangement whereby a third party payor contracts with a group of medical care providers known as preferred providers which includes physicians, hospitals,

laboratories, etc., who contract with the PP0 plan to furnish services at lower than usual fees in return for prompt payment and a certain volume of patients. The plan also allows for nonpreferred providers to furnish services. When services are received from preferred providers, the plan member will be responsible for a certain percentage of the bill; and the plan will pay the balance up to the contract amount. However, if services are received from a nonpreferred provider, the plan member will be responsible for a much larger percentage of the bill. PP0s typically require that an individual or family deductible be met on an annual basis before benefits are paid. In some cases, the PP0 may charge the member a copayment for certain medical services (i.e., $5.00 office visit). Most PPOs allow the member to submit claim forms directly or claims may be assigned to the provider of service for submission.

CCS shall authorize medical care for a child enrolled in a PPO to the most appropriate CCS-paneled provider, as per program policy regardless of whether the provider's status is preferred or nonpreferred with a specific PPO.

D. HEALTH MAINTENANCE ORGANIZATIONS (HMOs)

Definition: A HMO is a medical care organization which provides and delivers a predetermined set of comprehensive health maintenance and treatment services to group of individual subscribers for a prenegotiated payment. There are no individual or family deductibles to meet before benefits are payable and claim forms are not required. The HMO may charge the subscriber a copayment for certain medical services (i.e., $5.00 office visit or $3.00 prescription drug). Any medical services needed by the subscriber must be obtained from specific doctors and hospitals who contract with the particular HMO plan. The subscriber is required to select a primary physician or medical group who coordinates the health care. An HMO is an alternative to fee-for-service payment. A HMO can be sponsored by a variety of entities such as the government, medical schools, hospitals, employers, labor unions, consumer groups, insurance companies, and hospital/medical plans. These entities are licensed by the Department of Corporations and the insurance package is regulated by the Department of Insurance. Some examples of HMOs in California are: Kaiser, Foundation Health Plan, TakeCare, Health Plan of America, CIGNA, and Health Net.

1. CCS eligibility is not approved for applicants with HMO coverage except in situations when a needed service is not covered by the HMO. In these cases, CCS shall only cover those services that are verified in writing as noncovered HMO services. CCS coverage will commence upon receipt of a specific denial letter from the membership office of the carrier that contains information identifying the HMO name and address, statement of denial because service(s) is not a covered benefit, recipient's name, procedure description, date of denial, and signature of authorized membership services representative.

2. If the HMO covers all of the services needed by the CCS applicant or recipient at minimal or no cost to the family, CCS eligibility shall be denied or discontinued because of full health plan coverage.

3. CCS center care is not a benefit to HMO patients as diagnostic and/or treatment services for the CCS-eligible condition are otherwise available through the HMO provider network.

4. Prescriptions and services not covered by the HMO must be requested from and authorized to a CCS-paneled provider after review by the CCS program medical consultant or designee to determine medical appropriateness.

E. CHAMPUS - There are three plans available:

1. Standard plan is similar to indemnity plan.

2. Extra plan is similar to a PPO, and

3. Prime plan is similar to a HMO

The appropriate CCS policy as previously described is applicable to patients with CHAMPUS coverage. In addition, if there is a full service military facility in the community, these resources must first be utilized by eligible families.

F. MULTIPLE COVERAGE

Multiple coverage exists when family members are covered

under two or more health insurance plans. Generally, the primary plan (the plan that pays first) is determined by the coverage of the parent whose birthday comes first in the year (CCR, Title 10, Section 1300.67). Exceptions to this "birthday rule" exist for dependents whose parents are separated, divorced, remarried, or when financial responsibility was changed by court order. For further information or clarification, families or providers should contact a plan representative to assist in the coordination of benefits.

II. OTHER ISSUES RELATING TO HEALTH INSURANCE

A. MEDICAL THERAPY PROGRAM

1. All CCS patients with a medical therapy unit (MTU) eligible condition are eligible for MTU services irrespective of financial eligibility.

2. Children who are covered under a HMO plan are not eligible for the MTU conference. The HMO may hold its clinics for MTU-eligible children at the MTU, in that this preserves the comprehensive team approach. The HMO is solely responsible for processing all documentation generated at the clinics. Physician findings will be required documentation from these clinics; just as they would be for any privately prescribing physician.

B. PRIOR AUTHORIZATION

1. All insurance and health plan requirements concerning preadmission certification (e.g., for inpatient hospitalization) or prior authorization (e.g., for MRIs, CT scans, DME or other nonroutine benefits) must be adhered too in accordance with the contract or policy guidelines.

C. DEDUCTIBLES AND COPAYMENTS

Deductibles are per year charges and copayments are per visit charges the family is required to pay in order to qualify for the full extent of insurance payment of covered service(s).

1. Deductibles:

   Annual deductibles are dollar amounts that each patient or family is required to pay before insurance begins

payment for covered services. The amount of deductible may be more than a CCS family can afford. The usual practice is for the provider to bill insurance, with the insurance plan or carrier applying the benefit amount for the service(s) delivered towards the deductible, until the annual deductible amount is satisfied. In these cases, providers may then submit the bill to CCS for payment. CCS will then pay the claim at the CCS rate minus any payment made by the insurance plan or carrier.

2. Copayments:

Copayments are per visit charges such as a $3.00 per office visit that the provider is required to collect from the insured patient as part of the insurance reimbursement. The CCS family is required to pay these charges.

D. DRUGS

When a pharmacy is unwilling to bill the health insurance plan or carrier and the family is unable to pay for the drug prescription, CCS may pay the pharmacy and require the family to submit a claim form to the insurance plan or carrier. Upon receipt of a denial or payment from the insurance plan or carrier, the family is required to submit the claim information or payment to CCS.