LSU Health NEW ORLEANS
Louisiana Tumor Registry

Insurance Coding Guide

Currently the only guidance provided regarding insurance coding is what is provided in the CoC's FORDS/STORE manuals or the SEER Program Coding and Staging Manual—which to be honest is not that much.

Which Code Do I Select?

To assist our state registrars in selecting the most appropriate insurance coding for their facility's abstracts, the LTR has prepared the following insurance coding guidance: (most commonly used codes are listed first)

STANDARD PRIVATE INSURANCE: Code 10 vs 20/21

- **Code 10 [Insurance NOS]** is used when basically all you know is that the patient had "insurance" but you **do not know** whether it is an *Managed Care, HMO, PPO (network based)* OR *Fee-for-service*—where patient is free to go to any doctor or any hospital in any city/state—no networks involved (this model is rapidly deteriorating due to higher premium cost); *Medicaid*; *Medicare*; *Tricare*, *military*, *VA OR PHS*. In other words, the patient has a type of insurance that you cannot code to 20, 21, 31, 35, 60-68.
    - **Per SEER, use this code for "prisoners" when NO further information is available**

- **Code 20 [Managed Care—HMO/PPO]** is used ONLY when you know the patient had private insurance that was a **network model**—HMO, PPO etc.

- **Code 21 [Fee-for-Service]** is used ONLY when you know patient had private, **fee-for-service** based insurance-- where patient is free to go to any doctor or any hospital in any city/state—no networks involved.

MEDICARE Codes: [NEVER assume pt has Medicare solely based on pt's age (≥ 62YO) or disability status]

- **Code 60 [Medicare NOS]** is used when all you know is that the patient has "Medicare" unk if patient had supplement or not.

- **Code 61 [Medicare w/Supplement NOS]** is used when you know the patient had some other form of **secondary** insurance in addition to Medicare (Medicare has to be the primary insurance) but it is unknown whether it is a managed care plan—HMO/PPO OR a private pay supplement (the more costlier option)

- **Code 62 [Medicare Managed Care]** is used when patient has Medicare administered through a managed care plan—HMO/PPO like Humana Gold or Peoples Health etc—this is the more popular option due to little to no additional premium costs due to Social Security payment coverage

- **Code 63 [Medicare w/Private Supplement]** is used when patient has Medicare plus a private pay supplement from an insurance company such as BCBS or UHC—supplement; this in my opinion would also include the situation where a retired spouse is on Medicare but is also covered as a dependent on an employed spouses' company insurance. This would fall into the secondary insurance category which would pay any expenses NOT covered by Medicare.

- **Code 64 [Medicare w/Medicaid]** is only used when patient has **BOTH Medicare AND Medicaid.**

MEDICAID ONLY: Louisiana's Medicaid program, pursuant to R.S.9:1615(J), is currently managed by several **managed care organizations.** The contracted entities that manage and provide specified Medicaid benefits and services to ALL enrolled Medicaid Louisiana residents includes: *Aetna Better Health, Inc.; AmeriHealth Caritas Louisiana, Inc.; Community Care Health Plan of Louisiana, Inc. (AKA Healthy Blue Louisiana); Louisiana Healthcare Connections, Inc.; and United Healthcare of Louisiana, Inc.* ***As a result, code 31 should not be used in Louisiana as long as the managed care organization contracts are enforce.***

- **Code** 35 [Medicaid Managed Care] is used for all Louisiana Medicaid patients since they are ALL enrolled in Medicaid through a Managed Care program (HMO or PPO) pursuant to R.S.9:1615(J).

NO INSURANCE: Code 01 vs 02

- **Code 01 [Not Insured]** is used when a patient has no insurance and is basically indigent w/no ability to pay (hospital charity write-off case)
- **Code 02 [Not Insured, Self-Pay]** is used when a patient **has no insurance but possess the ability to pay.**

MILITARY/INDIAN INSURANCE

- **Code 65 [TRICARE (FKA CHAMPUS)]** is used when a patient is a military retiree or their dependent OR a military dependent who is **treated at a non-military facility who is providing medical services beyond those provided at a military medical facility.** Insurance is often clearly labeled as "TRICARE."
- **Code 66 [Military NOS]** is used when a patient is either military personnel or their dependents treated at a **military facility.**
- **Code 67 [Veterans Affairs]** is used for Veterans **treated at Veterans Affairs (VA) facilities**
- **Code 68 [Indian/Public Health Service]** is used for patients who receive care at either Indian or Public Health Service Facilities OR another facility whose medical costs are covered by either Indian or Public Health Service plans

UNKNOWN INSURANCE STATUS [This code should RARELY be used]

- **Code 99 [Unknown Insurance Status]** is used ONLY when it is unknown from the patient's medical record whether or not the patient is insured AND no additional information is available.
  - If you are unsure of the type of insurance the patient has based on the demographic data from the "face sheet," **remember to look for the scanned/Xeroxed insurance card in the EMR.**
    - **It is now standard practice for all facilities, including MD offices to scan insurance cards, so there is NO reason NOT to know the type of insurance at admission**
    - If not certain where this information might be located in your facility's EMR, please contact your IT department.

Insurance Coding Rules and Tips

Now that you understand the differences between the insurance codes, the LTR would like to provide some general coding rules from SEER/CoC for the coding of this data item along with some insurance location tips.

GENERAL CODING RULES

- Code the type of insurance reported on the patient's admission record
- Code the **first** insurance mentioned when multiple insurance carriers are listed on one admission record
- Code the type of insurance reported **closest to the date of diagnosis** when there are multiple insurance carriers reported for multiple admissions and/or multiple physician encounters
- Code the patient's insurance at the time of **initial diagnosis and/or treatment**. Do not change the insurance information based on subsequent information

CODING TIPS

- Keep in mind that at the time of abstraction (some 6 months s/p diagnosis—unless your facility is practicing concurrent abstracting), the patient's insurance status or type of insurance coverage *may have changed from that at the time of diagnosis*
    - Thus the current coverage shown as a default on the main demographics "face sheet" in your EMR is NOT necessarily the same insurance the patient had at diagnosis
- Always remember to check for **"ARCHIVED" coverage** in your facility's EMR. It may also be labeled as "Old Coverage" OR "Inactive Coverage" and is generally located in the Demographics section of the EMR.
    - If you cannot easily locate this data in your facility's EMR, contact your IT department. They will be happy to assist you either in locating this important data or providing you access to it if you are currently unable to view it due to restrictions
    - All facilities will maintain a patient's insurance history over time for billing purposes
- **EXAMPLES:**
    - Patient dxd 1 month before joining a Medicare HMO on his 65th birthday
    - Patient was dxd in December while on a Managed Care plan. Unfortunately the patient lost his job and provided insurance in February due to his illness then qualifying for Medicaid—when case the case is abstracted, Medicaid will be recorded as his default insurance