PHYSICIAN EMERGENCY SERVICES (PES) PROGRAM

Program Handbook
for
Physicians
in the
County of San Diego

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October 2016

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KEY POINTS TO REMEMBER

Registry for Payment

Each physician and provider group must submit a signed Registry for Payment and a completed Form W-9 before claims will be processed for that provider.

Allowable Services

Only uncompensated services provided in hospital emergency departments, or for an emergency inpatient admission up to the time the patient is stabilized up to a maximum of three (3) days or 48 continuous hours, are allowable services. Services provided in a physician's office are NOT covered.

Claims must be submitted no earlier than three (3) months from the initial billing date and no later than 365 days after the date of service.

Claims Submission Deadline	Claims For These Dates of Service May Be Submitted	Claims Payment Dates
09/30/16	07/01/15 – 09/30/15	11/15/16
12/31/16	07/01/15 – 12/31/15	02/15/17
03/31/17	07/01/15 – 03/31/16	05/15/17
06/30/17	07/01/15 – 06/30/16	08/15/17
Appeals only – Deadline 9/30/17	07/01/15 – 06/30/16	10/15/17

Remember: ***Physicians must make at least two (2) attempts to collect payment from other sources for at least three (3) months after the initial billing date and may submit claims up to 365 days after the date of service.***

Supplemental Information Form

Supplemental data required with each claim are patient ethnicity and emergency room disposition. All other demographic information is optional.

Forms

Claims must be submitted on a Universal Billing Form (CMS 1500). **Groups must indicate individual physician name, group name and taxpayer ID# on the CMS 1500**.

Electronic Data Interchange (EDI)

Electronic submission of claims is acceptable, but format **must be the 837 Transaction Code as mandated by the Health Insurance Portability and Accountability Act (HIPAA).**

Payment Methodology

Compensation will be based on a percentage of the physicians Medi-Cal fee schedule current at the time services were rendered. The percentage will be based on the amount of total PES funding available. Compensation cannot exceed 50% of the billed charges; therefore, physicians should bill at their **usual and customary** fee schedule.

Physicians Emergency Services Funding

The funding source for the PES Program is Maddy Emergency Medical Services (EMS) funds-a portion of criminal court fines, fees and forfeitures, including motor vehicle and traffic school fees as determined by state law.

Reports

Per Payment: Remittance advice accompanies payment checks.

Resubmissions

Denied claims may be resubmitted with additional information within 30 days of the date of denial, but no later than 30 days after the claims payment date.

BILLING REQUIREMENTS FOR (PES) PROGRAM

For the purposes of reimbursement from the PES Program, **emergency services and care** means medical screening, examination, and evaluation by a physician to determine if an emergency medical condition or active labor exists, and if it does, the care, treatment and surgery by a physician necessary to relieve or eliminate the emergency medical condition within the capability of the facility.

Emergency medical condition means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in any of the following:

- placing the patient's health in serious jeopardy
- serious impairment to bodily functions
- serious dysfunction of any bodily organ or part

Criteria for Payment Eligibility

1. Hospital based emergency services only are eligible for compensation. Payment will be made to a physician for services provided in the emergency department of a hospital with a permit to provide basic or comprehensive emergency services or for an emergency inpatient admission up to the time patient is stabilized or a maximum of three (3) days or 48 continuous hours, whichever is less.
2. Physician expressly acknowledges and understand that a claim(s) submitted for payment is for a patient(s) that: 1) Does/do not have health insurance for emergency services and care, or for whom payment will not be made through any private coverage; 2) cannot pay for emergency services; and 3) is not eligible for any program funded in whole or in part by the federal government, except for eligibility under section 1011 of the Federal Medicare Prescription Drug Improvement and Modernization Act of 2003.
3. The physician must make at least two (2) attempts to obtain reimbursement for his/her services from the patient, other responsible parties, or other funding sources before resorting to this Program. A bill is deemed uncollectible if at least three (3) months have passed from the date the physician initially billed the patient and/or responsible third party payors without receipt of any payment or notice from the patient or responsible third party that no payment will be made.
4. Physician expressly acknowledges and understands that this claim and any County liability thereon is subject to those conditions defined in the billing requirements, including, among others, (1) availability of monies in the PES Program and (2) audit and adjustments.
5. Payment to the physician from **any** source on a particular claim renders him/her ineligible to file for any payment on that claim with this program. Any revenue received subsequent to payment by this program requires a reimbursement in the amount of the program payment. This may be accomplished by:
    - Reducing the physician’s future claims by the amount collected, not to exceed the amount paid by the Program; or,
    - The physician reimbursing the County the amount collected, not to exceed the amount paid by the Program.
6. Physician or surgeon is not an employee of the hospital.

7. Physician must maintain records regarding these transactions for a period of three (3) years from the date of service. Such records must be available for audit by the County of San Diego or other appointed agencies. If records do not support the claim, a corresponding amount will be deducted from future payments.

CLAIMS PROCEDURES

Submission Guidelines

1. Claims will be considered only for physician services provided in an acute care hospital inpatient or emergency department setting. If the service(s) were provided by a credentialed nurse practitioner or physician's assistant, the claim(s) must be substantiated by a medical record. Also, the claim must be signed by both the nurse practitioner or physician's assistant and the supervising physician or surgeon in accordance with regulations for the supervisor of nurse practitioners and physician's assistant in California.

2. To be eligible for payment, physicians must have a Registry for Payment Form and a completed Form W-9 on file with the PES Program prior to submission of claims.

3. Compensation will be based on a percentage of the physicians Medi-Cal fee schedule current at the time services were rendered. Compensation cannot exceed 50% of the billed charges. Therefore, physicians should bill at their **usual and customary** fee schedule.

Submission and Claims Payment Dates

Claims must be submitted **no earlier** than three (3) months from the initial billing date and **no later** than 365 days following the date of service, and according to the following schedule:

Claims Submittal Deadline	Claims For These Dates Of Service May Be Submitted	Claims Payment Dates
09/30/16	07/01/15 – 09/30/15	11/15/16
12/31/16	07/01/15 – 12/31/15	02/15/17
03/31/17	07/01/15 – 03/31/16	05/15/17
06/30/17	07/01/15 – 06/30/16	08/15/17
Appeals only – Deadline 9/30/17	07/01/15 – 06/30/16	10/15/17

Claim Forms and Required Information

All claims should be submitted on the Universal Billing Form (CMS-1500). Electronic submission of claims is acceptable, but format **must be the 837 Transaction Code as mandated by the Health Insurance Portability and Accountability Act (HIPAA).**

The minimum data elements required to process a claim are as follows:

- Patient Name
- Patient Date of Birth
- Patient ID Number
- Provider Address
- CPT or RVS Code and Text
- ICD-9 Code
- Dates of Services Rendered
- Dates of Admission (if applicable)
- Full itemization of Charges
- Provider Tax I.D. Number
- MD Name and if applicable, Group Name
- Location of Service

NOTE: ***Claims submitted by groups must indicate the individual physician's name, the group name and the group's tax identification number in order for payment to be made in the group's name.***

Reimbursement for Denied CMS and Medi-Cal Claims

When requesting reimbursement for services that were denied by the County Medical Services (CMS) Program or Medi-Cal, always submit a claim plus the Explanation of Benefits (EOB) showing that the claim was denied to the address indicated below.

Supplemental Information

Each claim must be accompanied by the demographic information specified on the attached PES SUPPLEMENTAL INFORMATION FORM (copy attached). You may photocopy and use this form with claims submissions. Submission of this information in another format or on other media requires prior approval by the County of San Diego.

Failure to submit a complete claim with all the required data elements may result in delayed or denied reimbursement. Required data elements are ethnicity and emergency room disposition. Other data elements are optional.

Claims Submission Address

Claims should be sent to the following address:

Physician Emergency Services Program
Claims Department
P.O. Box 927140
San Diego, CA 92192

Resubmission Process

If a claim were submitted for payment from the PES Program and was denied, you may resubmit the claim with additional justification for re-evaluation within 30 days from the denial notification date, but no later than 30 days after the claims payment date.

Refund Process

If a payment is received from another payor source (i.e. patient, private insurance, third party liability, etc) after payment has been received from the PES Program, providers are required to refund the PES Program by reimbursing the County the amount collected, not to exceed the amount originally paid by the Program or if necessary the Program may reduce the physician's future claims by the amount collected, not to exceed the amount originally paid by the Program.

Inquiry and Information

For information or questions about the Physician Emergency Services Program or on specific claims, please contact:

Physician Emergency Services Program
email: COSD_claims@uhc.com
Fax: 855-394-7927

Please permanently file this correspondence as a guide for future reference. Updates are provided only in the event of a change in Program requirements.

Attachment A

PES Supplemental Information Form

Physician Emergency Services (PES) Program
Supplemental Information Form

Name:_____**SSN**:____-___-____ **DOB**:___/___/_____
Last First

Patient Demographic Information

A. **Ethnicity (Required)**:

1. ☐ White 2. ☐ Black
3. ☐ Hispanic 4. ☐ Asian
5. ☐ Native American/Eskimo 6. ☐ Other 7. ☐ Unknown

B. **Emergency Room Disposition (Required - to be completed by physician)**:
Complete only for claims for services provided in the emergency room. Indicate the appropriate emergency room disposition code:

1. ☐ Non-emergency, resulting in a release from the hospital.
2. ☐ Emergency, resulting in a release.
3. ☐ Non-emergency, resulting in a transfer to another hospital.
4. ☐ Emergency, resulting in a transfer to another hospital.
5. ☐ Non-emergency, resulting in a hospital admission.
6. ☐ Emergency, resulting in a hospital admission.

C. **Family Size (Optional):** ☐ Number
Indicate number of individuals sharing the same place of residence.

D. **Monthly Gross Income (Optional):** Please check one box:
Indicate total monthly gross Income for all related family Members currently residing In the household.

☐ $0-499 ☐ $2,000-2,499
☐ $500-999 ☐ $2,500-2,999
☐ $1,000-1,499 ☐ $3,000+
☐ $1,500-1,999

E. **Source of Income (Optional):**
Indicate category of primary source of family income (**Check one box only**).

1. ☐ Earnings 2. ☐ Self-employment earnings 3. ☐ Retirement
4. ☐ Disability 5. ☐ General or Public Assistance
6. ☐ Other (VA benefits, interest, dividends, rent, child support, alimony, etc.)
7. ☐ None 8. ☐ Unknown

F. **Type of Employment (Optional):**
Indicate category or occupation of family's primary wage earner.

1. ☐ Professional, technical, and related support 2. ☐ Production/laborers
3. ☐ Agriculture, forestry, fishing 4. ☐ Sales, service 5. ☐ Not employed

Attachment B

PES Registry for Payment Form

COUNTY OF SAN DIEGO, DEPARTMENT OF HEALTH SERVICES

PHYSICIAN EMERGENCY SERVICES PROGRAM

REGISTRY FOR PAYMENT FORM

PLEASE REPRODUCE BOTH PAGES AS NEEDED

1. Applicant Name:_____
2. Professional License Number:_____
3. Physician's Tax ID/Social Security Number:_____
4. National Provider Identifier #:_____
5. Applicant's Group Affiliations (If Applicable):_____

   _____
6. Group's Tax ID Number:_____
7. Group National Provider Identifier #:_____
8. Mailing Address:_____
9. Business Telephone:(____)_____
10. Primary Specialty of Physician:_____
11. Please list hospital(s) in San Diego County where you currently are credentialed to provide emergency services:

    HOSPITAL:

    1. _____
    2. _____
    3. _____

The Undersigned Physician Agrees To The Following:

1. All claims submitted by the undersigned physician are for medical screening, examination and evaluation by a physician to determine if an emergency medical condition or active labor exists; and if it does, the care, treatment and surgery by a physician necessary to relieve or eliminate the emergency medical condition within a hospital which has a permit to provide basic or comprehensive emergency medical services. Inpatient claims are for services provided up to the time the patient is stabilized.

2. All claims submitted for emergency services performed by a credentialed nurse practitioner or physician's assistant must be: 1) substantiated by a medical record, 2) reviewed by the supervising physician or surgeon; and 3) signed by both the nurse practitioner or physician's assistant and the supervising physician or surgeon.

3. Physician expressly acknowledges and understand that a claim(s) submitted for payment is for a patient(s) that: 1) Does/do not have health insurance for emergency services and care, or for whom payment will not be made through any private coverage; 2) cannot pay for emergency services; and 3) is not eligible for any

program funded in whole or in part by the federal government, except for eligibility under section 1011 of the Federal Medicare Prescription Drug Improvement and Modernization Act of 2003.

4. The physician must make at least two (2) attempts to obtain payment for his/her services from the patient, other responsible parties, or other funding sources before resorting to this Program. A bill is deemed uncollectible if at least three (3) months have passed from the date the physician initially billed the patient and/or responsible third party payors without receipt of any payment or notice of intent to pay during that period.

   Physician agrees to stop all current efforts and waives any future efforts to obtain reimbursement once payment has been received from the County and to immediately notify the county should payment be subsequently received from patient or other third party and to repay the Program within thirty (30) days, the amount collected, not to exceed the amount originally paid by the Program.

5. Physician acknowledges and agrees that payment for services provided under this claim shall be made in four (4) annual payments. Payment dates are specified in the PES Program Provider Handbook.

6. Physician or surgeon is not an employee of the hospital.

7. Physician expressly acknowledges and understands that this claim and any County liability thereon is subject to those conditions defined in the billing requirements, including, among others: (1) availability of monies in the Physicians Emergency Services Program; and (2) audit and adjustments.

8. Physician acknowledges receipt of a copy of the County of San Diego *Billing Requirements for Physician Emergency Services Program*, the terms and conditions of which are incorporated herein by reference. Physician certifies that he/she will comply fully with the terms and conditions stated therein in submitting each claim and that, in connection with each claim, all obligations, including, but not limited to, the preparation, maintenance and retention of service and finance records, and their availability for audit, will be observed by him/her. If records do not support the claim, a corresponding amount will be deducted from further payments.

   As a condition to claiming reimbursement from the County of San Diego Physician Emergency Services Program, I certify that the information submitted is true, accurate and complete to the best of my knowledge and that I will comply with the terms and conditions as stated herein.

_____ _____
Typed or Printed Name of Provider Date

_____
Signature of Provider

The Original Signed Copy of This Form Must Be Submitted To:

COUNTY OF SAN DIEGO
PHYSICIAN EMERGENCY SERVICES PROGRAM
CLAIMS DEPARTMENT
P.O. BOX 927140
SAN DIEGO, CA 92192