



# PHYSICIAN EMERGENCY SERVICES (PES) PROGRAM

Program Handbook  
for Physicians  
in the County of San Diego

*Prepared by:*

**AmeriChoice  
Physician Emergency Services (PES) Program  
PO BOX 927140  
San Diego, CA 92192  
(800) 587-8118**

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### KEY POINTS TO REMEMBER

#### *Registry for Payment*

Each physician and provider group must submit a signed Registry for Payment Form (see Attachment B) 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	Date(s) of Service	Claims Payment Dates
09/30/23	07/01/22 – 09/30/22	11/15/23
12/30/23	07/01/22 – 12/31/22	02/15/24
03/30/24	07/01/22 – 03/31/23	05/15/24
06/29/24	07/01/22 – 06/30/23	08/15/24
Appeals only – Deadline 9/30/24	07/01/22 – 06/30/23	10/15/24

**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 encouraged, 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

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funding available. Compensation cannot exceed 50% of the billed charges; therefore, physicians should bill at their **usual and customary** fee schedule.

### *Physicians Emergency Services (PES) 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 claim payment date.

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## 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 understands 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 their 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 and/or customer from **any** source on a claim renders them ineligible to file for any payment on that claim with this program. Any revenue received after 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,

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- 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.

**Note:** If criteria 1-7 above are **not** met, the claim is not eligible for payment.

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### 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 Submission Deadline	Date(s) of Service	Claims Payment Dates
09/30/23	07/01/22 – 09/30/22	11/15/23
12/30/23	07/01/22 – 12/31/22	02/15/24
03/30/24	07/01/22 – 03/31/23	05/15/24
06/29/24	07/01/22 – 06/30/23	08/15/24
Appeals only – Deadline 9/30/24	07/01/22– 06/30/23	10/15/24

#### *Claim Forms and Required Information*

All claims should be submitted on the Universal Billing Form (CMS-1500). Electronic submission of claims is encouraged, 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-10 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

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**NOTE:** *Claims submitted by groups must indicate the individual physician's name and NPI, the group name and NPI, and the group's tax identification number for the 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 ***PES Supplemental Information Form*** (see Attachment A). 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 claim's payment date.

### ***Refund Process***

If a payment is received from another payor source (for example, patient, private insurance, third party liability) 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](mailto: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

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## Physician Emergency Services (PES) Program Supplemental Information Form

Name: \_\_\_\_\_ SSN: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ DOB: \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
Last First

### Patient Demographic Information

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A. **Ethnicity (Required):**

- |  |                                   |                                     |
|--|-----------------------------------|-------------------------------------|
| 1. <input type="checkbox"/> White                  | 2. <input type="checkbox"/> Black |                                     |
| 3. <input type="checkbox"/> Hispanic               | 4. <input type="checkbox"/> Asian |                                     |
| 5. <input type="checkbox"/> Native American/Eskimo | 6. <input type="checkbox"/> Other | 7. <input type="checkbox"/> 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:

- Non-emergency, resulting in a release from the hospital.
  - Emergency, resulting in a release.
  - Non-emergency, resulting in a transfer to another hospital.
  - Emergency, resulting in a transfer to another hospital.
  - Non-emergency, resulting in a hospital admission.
  - Emergency, resulting in a hospital admission.
- 

C. **Family Size (Optional):**

Indicate number of individuals sharing the same place of residence.

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Number

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D. **Monthly Gross Income (Optional):** Please check one box:

Indicate total monthly gross Income for all related <u>family</u> Members currently residing In the household.	<input type="checkbox"/> \$0-499	<input type="checkbox"/> \$2,000-2,499
	<input type="checkbox"/> \$500-999	<input type="checkbox"/> \$2,500-2,999
	<input type="checkbox"/> \$1,000-1,499	<input type="checkbox"/> \$3,000+
	<input type="checkbox"/> \$1,500-1,999	

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E. **Source of Income (Optional):**

Indicate category of primary source of family income (**Check one box only**).

- |  |  |  |
|--|--|--|
| 1. <input type="checkbox"/> Earnings   | 2. <input type="checkbox"/> Self-employment earnings     | 3. <input type="checkbox"/> Retirement |
| 4. <input type="checkbox"/> Disability   | 5. <input type="checkbox"/> General or Public Assistance |  |
| 6. <input type="checkbox"/> Other (VA benefits, interest, dividends, rent, child support, alimony, etc.) |  |  |
| 7. <input type="checkbox"/> None   | 8. <input type="checkbox"/> Unknown                      |  |
- 

F. **Type of Employment (Optional):**

Indicate category or occupation of family's primary wage earner.

- |  |   |  |
|--|---|--|
| 1. <input type="checkbox"/> Professional, technical, and related support | 2. <input type="checkbox"/> Production/laborers |  |
| 3. <input type="checkbox"/> Agriculture, forestry, fishing               | 4. <input type="checkbox"/> Sales, service      | 5. <input type="checkbox"/> Not employed |

**Attachment B**

**PES Registry for Payment Form**

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**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 (if sole proprietor): \_\_\_\_\_
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)

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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 their 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 them. 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**