MONTEREY COUNTY HEALTH DEPARTMENT
Emergency Medical Services Agency
Fund Reimbursement Procedures

I. **INTRODUCTION.** In 1989, the Monterey County Board of Supervisors established the County Emergency Medical Services Fund (EMSF) under Section 1797.98 of the Health and Safety Code. Management of the EMSF is provided by the Health Department where the Emergency Medical Services Division administers it. What follows are detailed procedures established for the management of the physician's portion of the fund. These procedures incorporate the latest legislative changes and supersede all previous EMSF information sent to physicians.

The background section that follows provides historical and legislative information regarding the EMSF. The claiming procedures section summarizes the major activities in the claiming process and outlines physicians' responsibilities. To minimize problems associated with claim rejection, it is recommended that physicians familiarize themselves with these procedures and their responsibilities in the claiming process.

II. **BACKGROUND.** The Monterey County Board of Supervisors "to provide limited funding to partially offset the losses providers would incur for treating unsponsored patients who arrive in need of emergency care" established the EMSF.

A. Senate Bill No. 12 (1987), later amended by Senate Bill No. 612 (the EMSF is often referred to as the "612 funds"), first established the EMSF. It provided for reimbursement to physicians for non-paying patients who had been given emergency medical services in general acute care hospitals with facilities to provide such services. The regulation allows compensation only for hospital-based emergency services provided up to the point the patient is stabilized. In 1991, Senate Bill No. 946 clarified changes and amendments to SB 12. This included an easing of data requirements, limiting reimbursement to services rendered within 48 hours of the start of treatment, coverage of emergency screening exams required by law to determine if an emergency exists, and requiring that services billed must have been personally provided by the claiming physician.

B. Assembly Bill 1833 (2002) revised procedures for payment of claims against the fund from an annual disbursement to a quarterly disbursement. It also requires administering agencies to make all reasonable efforts to notify physicians and surgeons who provide or are likely to provide emergency services in the county as to the availability of the fund and the process by which to submit a claim against the fund.

III. **CLAIMING PROCEDURES FOR MADDY FUNDS.**
Physicians to qualify for reimbursement under the regulations previously cited must follow the claiming procedures below.

A. **Definitions.** Definitions are provided to clarify the claiming procedures that follow.

1. "Emergency Services" are physician services provided to a patient experiencing an emergency medical condition in an acute care hospital licensed to provide basic or comprehensive emergency services.

2. "Emergency Medical Condition" is a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain which, in the absence of immediate medical attention, could reasonably be expected to result in any of the following:

    a. Placing the patient's health in serious jeopardy.

    b. Serious impairment to bodily functions.

    c. Serious dysfunction to any bodily organ or part.

3. "Emergency Screening Exam" is a medical examination conducted in an acute care hospital licensed to provide basic or comprehensive emergency services that is required by law to determine whether an emergency medical condition exists, notwithstanding the determination after the examination that a medical emergency does not exist.

4. "Obstetric Service" refers to the diagnosis of pregnancy and all other related medical services provided by a licensed physician to pregnant women during their pregnancies from the time of conception until 90 days following the end of the month in which the pregnancy ends. *Claims for EMSF must include a report noting the emergency condition.*

5. "Pediatric Services" include all medical services rendered by any licensed physician to persons from birth to 21 years of age, including attendance at labor and delivery. *Claims for EMSF must include a report noting emergency condition.*

6. "SB 12" means Senate Bill No. 12 and all its amendments which refer to Health and Safety Code, Section 1797.98 that establishes and governs the EMSF and the conditions under which physicians may claim for uncompensated emergency services.

B. **Requirements for Submission of Claims.** The following conditions must be met to qualify for submission of all claims.

- ***Emergency medical services must have been personally provided by a licensed physician*** on an inpatient or outpatient basis in a general acute care hospital in

Monterey County that has a permit to provide basic or comprehensive emergency medical services. Acceptable acute care hospitals in Monterey County include

- Community Hospital of Monterey Peninsula
- George Mee Memorial Hospital,
- Natividad Medical Center
- Salinas Valley Healthcare System

2. Eligible emergency medical services will include only services provided on the calendar day on which the services were first provided (initial date of entry to the emergency room) and on the immediately following two calendar days. Reimbursement will not be made for services provided beyond a 48-hour period of ***continuous service*** to the patient.

3. Notwithstanding 2. above, if it is necessary to transfer the patient to a second facility providing a higher level of care for the treatment of the emergency condition, reimbursement shall be available for services provided at the facility to which the patient was transferred on the calendar day of transfer and on the immediately following two calendar days; however, reimbursement will not be made for services provided beyond a 48-hour period of ***continuous*** *service* to the patient.

4. Physician services provided in a facility that receives AB 75 funds are not eligible for additional reimbursement from SB 12 funds for losses incurred in the provision of those services.

5. Reimbursement is limited to services for which the physician has not received *any* payment from the patient, a responsible relative, or a third-party payor following reasonable billing efforts.

6. Reimbursement for losses incurred due to patients for whom no payment is received is restricted to the following:

   a. Patients for whom the physician has inquired if there is a responsible private or third-party source of payment.

   b. Patients for whom the physician expects to receive NO reimbursement for the services provided.

   c. Patients for whom the physician has billed for payment or has billed a responsible private or third party.

   d. Patients for whom the physician has made reasonable efforts to collect payment. *A reasonable effort is considered to be sending one billing and two follow-up statements to individual payors over a three-month period of time; complying with standard claiming requirements established by*

third-party payors; and making all normal appeals to private and governmental third-party insurance programs.

e. Claims that have been rejected for payment by the patient and any responsible third-party. Rejection is considered to be either of the following:

(1) A period of not less than three months has passed from the date the physician billed the patient or responsible third-party, during which time the physician has made reasonable efforts to obtain payment and has not received payment for any portion of the amount billed;

or

(2) The physician has received actual notification from the patient or responsible third-party that no payment will be made for the services rendered by the physician.

7. Upon receipt of reimbursement from EMS Fund, the physician must stop all current, and waive any future, collection efforts to obtain payment from the patient. This requirement does not prevent a physician from continuing to seek payment from a patient or responsible party at any time prior to receiving reimbursement from the funds.

C. **Procedures for Submission of Claims.** The following procedures apply to claims submitted to the Monterey County Emergency Medical Services Emergency Medical Services Agency (EMSA) for reimbursement from the EMSF account.

1. All claim hard copies should mailed directly to:

Monterey County Emergency Medical Services
Emergency Medical Services Agency (EMSA)
EMS Fund
1441 Schilling Place, South Building
Salinas, CA 93901

To ensure compliance with HIPAA privacy requirements, all claim hard copies must are placed in ***two*** envelopes. The first sealed and marked "confidential." The second addressed to the EMS Agency.

2. Electronic submittal of claims must be done via a **secure FTP.**

3. All claims must be submitted on an HCFA-1500 form for **each patient** *(Attachment A).* Each claim *must include* the information detailed on *Attachment B.* Exception to the requirement is if the claim(s) are submitted electronically. In

this case the information must be submitted according to the format required by the EMS Agency.

4. For emergency services claims, the ICD-10 diagnosis code must describe an accepted emergency condition, or an explanation must be attached describing the emergency nature of the patient's condition. A *legible* copy of the emergency room report **may** be submitted, but is not required, to document an emergency service.

5. A MADDY EMERGENCY MEDICAL SERVICES FUND ENROLLMENT form must be completed annually in July *(Attachment* C).

D. Account Administration and Reimbursement

1. For all claims submitted, either a payment will be made on the claim as described previously, or a written notice of denial will be sent.

2. Upon receiving reimbursement, the physician agrees to accept the reimbursed amount as payment in full and will not attempt to collect from the patient or responsible third-party the difference between the amount reimbursed and the amount originally billed. This shall not be construed to prohibit the physician from attempting to collect payment prior to receipt of the reimbursement.

3. Reimbursement shall be made at 50% of the current Medi-Cal rate for services provided. Reimbursement is contingent upon the availability of monies specifically allocated to the account on which the claim is made.

4. Payments for all properly submitted claims will be processed quarterly. Distribution will be made according to the attached *Schedule D.* If claims exceed the account revenue plus any previously unclaimed account balance, reimbursements will be pro-rated so as not to exceed available funding.

5. Rejected claims will be returned to the physician with an explanation as to why the claim was rejected. Claims rejected for technical reasons may be resubmitted for processing as long as they arrive within the allowable time period specified below. Physicians receiving claims rejected due to a finding that the service provided did not qualify as an emergency condition or an emergency screening exam, may appeal the decision to the EMS Agency Administrator. If the rejection is upheld by the Administrator, the physician may appeal to the Director of Health who will review the decision and make a determination. If the decision is subsequently upheld by the Director of Health, the physician may request that the decision be submitted to a panel of physicians. The decision of the panel shall be final. Any expenses associated with arbitration shall be shared equally between the appellant and the County.

E. **Fund Reimbursements and Record Keeping Requirements.** The following outlines responsibilities of physicians who receive EMSF reimbursement for uncompensated medical services.

1. If a physician receives a payment from a patient or responsible third-party for services that were reimbursed by EMSF, the physician will notify the EMS Agency in writing and provide the patient's name, date of services and either:

    a. Refund the account in the amount equal to the amount collected from the patient or other payor, but not more than the amount of reimbursement received from the fund for care of that patient (checks should be made to "Monterey County Health Department"): or

    b. Elect to have the fund reduce payment on a future claim by the amount collected from the patient or other payor, but not more than the amount of reimbursement received from the fund for care of that patient. In the event that a claim is not submitted by the physician within one year of receiving such a payment from the patient or other payor, the physician must make a refund as stated in the previous paragraph.

2. Physicians who receive reimbursement from EMS funds must keep and maintain records of the services rendered, the person to whom rendered, the dates of the service, and documentation of collection efforts. These records must be kept for a period of three years from the date the services were rendered.

3. With reasonable notice, the EMS Agency may make an inspection and examination of the physician's books and records to verify compliance with the conditions and requirements as set forth in these policies and procedures. Any claim found to not be adequately supported by the physician's records is subject to recoupment by the fund from which the claim was reimbursed.

4. Physicians who submit claims for reimbursement that are inaccurate or unsupported by records may be determined to be ineligible to submit further claims to the fund. Physicians determined to have knowingly submitted false claims for reimbursement will be reported to the District Attorney's Office for possible prosecution for civil fraud.

Attachment A

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA PICA

CARRIER

1. MEDICARE (Medicare#) MEDICAID (Medicaid#) TRICARE (ID#/DoD#) CHAMPVA (Member ID#) GROUP HEALTH PLAN (ID#) FECA BLK LUNG (ID#) OTHER (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. RESERVED FOR NUCC USE

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

ZIP CODE TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES NO PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes*, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED ____ DATE ____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED ____

PATIENT AND INSURED INFORMATION

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.

15. OTHER DATE QUAL. MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a. 17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.

A. B. C. D.
E. F. G. H.
I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1								NPI	
2								NPI	
3								NPI	
4								NPI	
5								NPI	
6								NPI	

PHYSICIAN OR SUPPLIER INFORMATION

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. b.

33. BILLING PROVIDER INFO & PH # ( )

a. b.

SAMPLE

COUNTY OF MONTEREY | HEALTH DEPARTMENT

Emergency Medical Services Agency

1441 Schilling Place, South Building, Salinas, CA 93901 | PH: 831-755-5013 | FX: 831-755-8040

EMS Fund (MADDY) Enrollment Form

Completion of the enrollment form is required **a)** annually in July **b)** when the physician's license expires prior to the month of July, or **c)** when the physician information (e.g. group, billing company) changes.

PHYSICIAN INFORMATION

Physician's Name			
Address		City	
State		Zip	
Telephone		Email	

State License #	
Expiration Date	
NPI#	

PLEASE NOTE: It is the physician's responsibility to maintain currently license information on file with EMSA. Failure to maintain current license information will result in denial of claims.

CLAIM PAYMENT INFORMATION

Payee Name			
Entity Type	☐Individual ☐Sole Proprietor ☐Partnership ☐Corporation		
Payee Address		City	
State		Zip	
Telephone		Fax	

If using a billing or management company, please provide the following information.

Company Name			
Company Address		City	
State		Zip	

ENROLLMENT For questions please contact the individual below.

Contact Name		Email	
Telephone		Fax	

CLAIMS For questions please contact the individual below.

Contact Name		Email	
Telephone		Fax	

ACKNOWLEDGEMENT

The undersigned acknowledges the following:

- Participation in the program requirement annual enrollment
- Receipt of 1) a copy of the Monterey County Emergency Medical Service Fund Reimbursement Procedures, including 2) a copy of the disbursement schedule and 3) the Field Completion Requirements table, which includes links to pertinent document and source of information.

The undersigned also certifies, under penalty of perjury, that the information provided in this enrollment form and that claims submitted for reimbursement are true, accurate, and complete to the best of his/her knowledge.

Physician's signature: ______________________ Date:

For questions and enrollment for submittal please contact:

Carolina Coyt
Accountant I

PH: (831) 755-4964
FX: 831) 775-8040

Email: coytc@co.monterey.ca.us

You can submit this form using Acrobat Reader

Monterey County Health Department

Emergency Medical Services Agency

EMS Fund (MADDY) Distribution Schedule

<table>
<tr><th>Quarter</th><th>Patient Date of Service</th><th>Required Collection Period</th><th>Claim Submittal</th><th>Distribution</th></tr>
<tr><td rowspan="3">First</td><td>JUL 1-31</td><td rowspan="12">1.
A period of not less than <u>three (3) months</u> has passed from the date the physician billed the patient or responsible third-party, during which time the physician has made reasonable efforts* to obtain payment and <u>has not received payment for any portion of the amount billed</u>, or

2.
The physician has received actual notification from the patient of third party that no payment will be made for the service s rendered by the physician.</td><td>OCT - DEC</td><td rowspan="3">End of January</td></tr>
<tr><td>AUG 1-31</td><td>NOV - DEC</td></tr>
<tr><td>SEP 1-30</td><td>DEC</td></tr>
<tr><td rowspan="3">Second</td><td>OCT 1-31</td><td>JAN - MAR</td><td rowspan="3">End of April</td></tr>
<tr><td>NOV 1-30</td><td>FEB - MAR</td></tr>
<tr><td>DEC 1-31</td><td>MAR</td></tr>
<tr><td rowspan="3">Third</td><td>JAN 1 -31</td><td>APR - JUN</td><td rowspan="3">End of July</td></tr>
<tr><td>FEB 1-29</td><td>MAY - JUN</td></tr>
<tr><td>MAR 1-31</td><td>JUN</td></tr>
<tr><td rowspan="3">Fourth</td><td>APR 1-30</td><td>JUL - SEP</td><td rowspan="3">End of October</td></tr>
<tr><td>MAY 1-31</td><td>AUG - SEP</td></tr>
<tr><td>JUN 1-30</td><td>SEP</td></tr>
</table>

* Reasonable effort is considered to be sending one billing and two follow-up statements to individual payers over a three month period of time; complying with standard claiming requirements established by third-party payers; and making all normal appeals to private and governmental third-party insurance programs.

Attachment B

MONTEREY COUNTY EMERGENCY MEDICAL SERVICES AGENCY (EMSA) MADDY FUND

FIELD COMPLETION REQUIREMENTS HCFA - 1500 FORM

The following table outlines the information needed to process EMSF claims using the HCFA form 1500. Fields not listed are considered not applicabl e

To ensure compliance with HIPAA requirement s, all paper claims must be placed in two envelopes. The first sealed and marked "confidential." The second addressed to the EMS Agency.Electronic claims submittals must be done via a secure FTP

Field	INFORMATION TO BE	STATUS		NOTES *(Please refer to the reimbursement procedures for complete and more detailed information)*
1a	Insured Social Security Number	If available	Claim not denied if missing	
2	Patient's Name	Required	claim denied if missing	
3	Patient's birth date	Required	claim denied if missing	
4	Patient's Sex	Required	claim denied if missing	
5	Patient's address	If available	Claim not denied if missing	
10a, b, c	Condition Related to:	Required	claim denied if any box is checked "yes"	An answer must be checked for each box
14	Date of current illness or injury	Required	claim denied if missing	
18	Inpatient admission and discharge dates	If available		Only if patient was hospitalized
21	Diagnisis code: ICD 10 codes	Required	Claim denied if missing or incorrect	County uses website to verify codes:
24a	Date of service (*from* and *to*)* ***Both boxes for the *from* and *to* dates must be filled out**	A Date in each box is required	Claim denied if missing of if received before end of required collection period. Initial date of entry to ER and the Immediately following two calendar days. If patient is transferred to a second facility, reimburement is available for services provided on the calendar day of the transfer and on the immediately following two calendar days.	* A period of *no less than three months* has passed **from date patient or responsible third-party was billed.** *Reasonable efforts to collect were made (e.g. one billing and two follow -up state ments). **No payment for any portion* of the amount billed is received .
24b	Place of service	Required	Claim denied if missing or if not consistent with Box 32	Home - Centers for Medicare & Medicaid Services | CMS
24d	Service: 1974 RVS code or CPT-4 code, including Procedure Type. The **Procedure type is usually a letter that follows the CPT code. The procedure type must be included on the claim, immediately following each CPT code. Refer to Medi-cal Notes to Rates:**	Required	claim denied if missing.If claim contains codes not found in CPT-4 code, County will approve services for which rate is found and deny those services for which a rate is not found based on code provided.	Medical rate is applied to these codes downloaded from State's website This rate information is an extract of pricing data from the automated Medi-Cal pricing system as of the specific date shown. It lists the maximum reimbursement rates payable by the Medi- Cal program for covered procedures described in the HCPCS and *CPT-4 coding system* .
24f	Usual and customary charge	Required	Claim denied if missing	Each box must be complete
24g	Units of service	Required	Claim denied if missing	
26	Patient's account or record number	Required	Claim denied if missing	
28	Total Charges	Required	Claim denied if missing	
29	Amount Paid	Required	Claim denied if missing or if payment was collected	
30	Balance Due	Required	Claim Denied if missing	
31	Signature of Physician or statement indicating that signature is on file	Required	Claim denied if missing or if service were not provided in a facility	Emergency medical services must have been *personally* provided by a licensed physician .
32	Name of facility where service was provided	Required	claim denied if missing or if services were not provided in a facility as described in the notes	Services can only be provided in a general acute care hospital in Monterey County that has a permit to provide basic or comprehensive emergency medical services. Acceptable acute care hospitals in Monterey County include: • Community Hospital of Monterey Peninsula (CHOMP) • George l. Mee Memorial Hospital • Natividad Medical Center • Salinas Valley Healthcare System
33	Billing provider information	Required	claim denied if missing	