To: Maddy Fund (EMS Fund) Physician Claimants

From: Travis Kusman, EMS Director

Date: February 2020

Subject: Maddy Fund Guidelines

Maddy (EMS Fund/SB12 Fund) physician claims procedures reflected in this document are current. Past changes have included accelerated claims submission and processing schedules and voluntary electronic claims submission. Our goal is to pay all eligible physician claims as quickly and fully as possible. These past changes went into effect January 1, 2003.

If you have any questions about the new procedures, or the San Mateo County Maddy Fund in general, please contact us.

GENERAL GUIDELINES

The San Mateo County Health Services Agency manages the SB12 Fund. The Emergency Medical Services (EMS) Agency administers the fund on behalf of Health Services.

According to the law, physicians can be reimbursed for uncompensated emergency medical care by the fund "to a maximum of 50% of their losses." The actual amount of reimbursement will be determined by the total funds available to reimburse physicians and the amount of eligible claims submitted within the fund disbursement cycle. If there are insufficient funds to pay all eligible claims at the highest level, Health Services will equitably prorate payments so that the amount of payment from the fund is based upon the magnitude of the physician's losses.

We use a uniform fee schedule for all claims.

The fund disbursement cycles shall occur at three-month intervals (quarterly). Each disbursement cycle will have eligible patient service dates. Claims must be received at our office by the due date for claim submission for the applicable service date cycle. Following the submission due date of claims for the eligible time period, there will be a 90 day period for Health Services to review the claims, summarize all eligible claims and determine the prorate payments to physicians.

Health Services reserves the right to audit all claim submissions, including on a retroactive basis. Upon EMS Agency request, claim documentation will be submitted to the EMS Agency in hard copy for audit.

Dates of patient services are due on a quarterly basis. The claim submission due dates are listed below. <u>It is essential that claims be submitted by the submission deadlines.</u>

PATIENT SERVICE DATES	CLAIMS SUBMISSION DEADLINE	CLAIM CYCLE REFERENCE
1/1/16 - 3/31/16	7/31/16	2016A
4/1/16 - 6/30/16	10/31/16	2016B
7/1/16 - 9/30/16	1/31/17	2016C
10/1/16 - 12/31/16	4/30/17	2016D

PATIENT SERVICE DATES	CLAIMS SUBMISSION DEADLINE	CLAIM CYCLE REFERENCE
1/1/17 – 3/31/17	7/31/17	2017A
4/1/17 – 6/30/17	10/31/17	2017B
7/1/17 – 9/30/17	1/31/18	2017C
10/1/17 – 12/31/17	4/30/18	2017D

PATIENT SERVICE DATES	CLAIMS SUBMISSION DEADLINE	CLAIM CYCLE REFERENCE
1/1/18 – 3/31/18	7/31/18	2018A
4/1/18 – 6/30/18	10/31/18	2018B
7/1/18 – 9/30/18	1/31/19	2018C
10/1/18 – 12/31/18	4/30/19	2018D

PATIENT SERVICE DATES	CLAIMS SUBMISSION DEADLINE	CLAIM CYCLE REFERENCE
1/1/19 – 3/31/19	7/31/19	2019A
4/1/19 – 6/30/19	10/31/19	2019B
7/1/19 – 9/30/19	1/31/20	2019C
10/1/19 – 12/31/19	4/30/20	2019D

PATIENT SERVICE DATES	CLAIMS SUBMISSION DEADLINE	CLAIM CYCLE REFERENCE
1/1/20 – 3/31/20	7/31/20	2020A
4/1/20 – 6/30/20	10/31/20	2020B
7/1/20 – 9/30/20	1/31/21	2020C
10/1/20 – 12/31/20	4/30/21	2020D

Payments should be received by the claimant approximately three months after the claims submission due date.

ELIGIBILITY CRITERIA FOR CLAIMS

A. The physician services must have been provided in either a San Mateo County Receiving Hospital emergency department or within the hospital following admission from the emergency department.
B. The physician services must have been provided on the calendar day on which the patient arrived at the emergency department or the immediately following two calendar days.
C. Notwithstanding B. 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, payments will not be made for services provided beyond a 48-hour period of continuous service to the patient.

D. The physician has not received **any** payment from the patient or any third party payer including the state or federal government for services provided to the patient.
E. The physician has inquired if there is a responsible private or public third-party source of payment.
F. The physician has billed the patient for payment of services and made two attempts to obtain payment.
G. Physicians, or a physician group, with a gross billings arrangement with a hospital shall not be entitled to receive reimbursement from the Emergency Medical Services Fund for services provided in that hospital, unless the:
    1. Physician is an emergency physician
    2. Services are provided in a basic or comprehensive general acute care hospital emergency department; and
    3. The physician is not an employee of the hospital.
H. Either of the following has occurred following the billing for services:
    1. A period of not less than three months has passed from the date the physician and surgeon billed the patient or responsible third party, during which time the physician and surgeon has made two attempts to obtain reimbursement and has not received reimbursement for any portion of the amount billed, or
    2. The physician and surgeon has received actual notification from the patient or responsible third party that no payment will be made for the services rendered by the physician and surgeon.
I. The physician has stopped any current, and waives any future, collection efforts to obtain reimbursement from the patient, upon receipt of funds from the fund.

PHYSICIAN CERTIFICATION

A signed Physician Certification form must be on file at the San Mateo County EMS Agency. (See attached form.) Complete the form and mail to our office. The form must include the physician's original signature. Copies of physician signatures and signature stamps are unacceptable.

APPEAL PROCESS

If a claim is rejected by the County for any reason, the physician may file an appeal with the EMS Agency. This appeal must be filed in writing and cite the specific reason that the physician believes that the claim should be reconsidered. The appeal must be received by the EMS Agency no later that 30 days from the date that the physician was notified that the claims was being rejected.

The appeal will be referred to the San Mateo County Medical Society for resolution. The Medical Society will render its decision with 60 days of receiving the appeal. The decision of the San Mateo County Medical Society shall be binding on the physician and on the County.

FILING CLAIMS

A. Submitting Claims By "Hard Copy"

Submit the completed claim by the Claims Deadline specified for the patient service dates. Claims should be submitted as close to the due date as possible. Claims submitted more than thirty days prior to the due date will be returned.
*Mail the claim to:

EMS Agency
801 Gatewway Blvd., Ste. 200
South San Francisco, CA 94080

**We recommend sending the claims Certified with Return Receipt Requested or via shipping that requires a signature of receipt. This will provide you with documentation that we have received your claims.*

Each claim must include the following information:

- The physician's type of medical practice (e.g. emergency medicine, orthopedics).
- The hospital at which the services were provided.
- The date the service was provided.
- The patient's name and address.
- The patient's hospital medical record number.
- A copy of the patient's emergency department admission record.
- The procedures performed on the patient, and being claimed, to include their CPT codes.
- The claim must indicate the following:
  - ➢ The physician has inquired if there is a responsible private or public third-party source of payment.
  - ➢ The physician has billed the patient for payment, or has billed a responsible private or public third party. **Copies of such bills must be attached to the claim**.
- The claim must include written documentation of:
  - ➢ Actual notification from the person, responsible third party, or governmental agency that no payment will be made for the services rendered by the physician, or
  - ➢ The passage of three months time from the date the physician has billed the patient and that reasonable efforts have been made to obtain reimbursement from the responsible third parties or governmental agencies.

B. Submitting Electronic Claims

If your agency wishes to submit claims electronically, these procedures for filing claims electronically must be followed. If you are submitting claims electronically, hard copy claims will not be accepted, unless prior approval is received from the EMS Agency. You must notify the EMS Agency of your intent to submit electronically in order to ensure proper implementation. All due dates and claiming cycles identified in the General Guidelines are applicable.

Use the following information when formatting your data for claim submission. Once you have accomplished the formatting, you must coordinate a test data transfer with the EMS Agency. Unless there is a change to the format of how data is to be formatted, the testing portion of the process will be required for the first submission only.

Submitting Your Data

All data must be submitted to the EMS Agency on disk, cd-rom or via email, and secured with a password. The password is to be provided to the EMS Agency under a means other than which the data was sent (e.g., if you send the data on cd-rom, the password can be sent to the EMS Agency via email).

When data is submitted, the following support information must also be provided:

Total number of claims being submitted
Total dollar amount of claims.

Data Format

The preferred format for submitting SB12 claims is in an Access database.

- Contact the EMS Agency for your code used to name the database followed by the allocation number, e.g., CEP2002C.
- Name the table “Claims” followed by the allocation, e.g., Claims2002C. The table layout is below.
- All fields are required and all fields are text.

One record will be submitted for each CPT code and charge for the patient’s visit.

- If one visit has 5 charges, 5 records will be submitted. The charge on each record is for the CPT code for that service.
- The “ClaimNo” field is the unique identifier for each visit; therefore, those 5 records will all have the same “ClaimNo”.

Formatting the CPT Codes

- When the CPT Codes are formatted, they will need to have the two digit modifier removed so that you are submitting the five digit CPT Code only.

Claim Denial

Claims may be rejected for the following reasons:

1. Any field is left blank.
2. An invalid code is used for HospCode, PtGender or DrType.
3. The AdmitToERDate is not within the claim cycle, e.g., if the AllocNum = 2002C, the AdmitToERDate must be between 07/01/2002 and 9/30/2002.
4. The ServiceDate must be within 2 days of AdmitToERDate, e.g., if patient is admitted on 07/04/2002, the ServiceDate must be <= 07/06/2002.
5. There is more than one AdmitToERDate for a claim number.

Codes

Codes for HospCode in record layout:

Code	Description
MIL	MILLS
PEN	PENINSULA
SEQ	SEQUOIA
SET	SETON
SMG	SAN MATEO MEDICAL CENTER
STC	SETON COASTSIDE
SUH	STANFORD UNIVERSITY HOSPITAL

Codes for PtGender in record layout:

Code	Description
F	Female
M	Male
O	Other
U	Unknown

Codes for DrType (specialty):

Code	Description
ANES	ANESTHESIOLOGIST
CAR	CARDIOLOGY
DERM	DERMATOLOGY
EMR	EMERGENCY MEDICINE
ENT	EAR,NOSE,THROAT
GAST	GASTROENTEROLOGY
IMD	INTERNAL MEDICINE
INF	INFECTIOUS DISEASE
INTE	INTERNIST
NEPH	NEPHROLOGY
NEU	NEUROLOGY
NSU	NEUROSURGEON

Code	Description
OBGYN	OBSTETRICS/GYNECOLOGY
OPT	OPTOMETRY
ORTHO	ORTHOPEDICS
OTH	OTHER
PATH	PATHOLOGY
PCC	FAMILY PRACTICE
PED	PEDIATRICS
PLS	PLASTIC SURGERY
PRI	PRIMARY CARE
RAD	RADIOLOGY
SUR	SURGERY
URO	UROLOGY

Table Layout

Field Name	Description	Data Type	Size	Format	If value is unknown, fill with the following:
AllocNum	Allocation #	Text	5	Ex: 2001B	
HospCode	Hospital where service was performed	Text	3	Use codes from below	
ClaimNo	Unique identifier for the patient visit	Text	20		
PTMRN	Patient Medical Record #	Text	12		
PTLastName	Patient Last Name	Text	20		
PTFirstName	Patient First Name	Text	20		UNKNOWN
PTAddress	Patient Street Address	Text	30		UNKNOWN
PTCity	Patient City	Text	15		UNKNOWN
PTState	Patient State	Text	2		XX
PTZip	Patient Zip Code	Text	9	999999999 (no hyphen)	UNKNOWN
PTDOB	Patient Date of Birth	Text	10	MM/DD/YYYY	UNKNOWN
PTSSN	Patient Social Security #	Text	9	999999999 (no hyphens)	UNKNOWN
PTGender	Patient Gender	Text	1	Use codes from below	
DrNo	Dr's. State License #	Text	15		
DRLastName	Dr. Last Name	Text	20		
DRFirstName	Dr. First Name	Text	20		
BillingFedTaxID	Federal Tax ID# for Billing	Text	20		
BillingName	Billing Name	Text	50		
BillingAddress	Billing Street Address	Text	30		
BillingCity	Billing City	Text	15		
BillingState	Billing State	Text	2		
BillingZip	Billing Zip Code	Text	9	999999999 (no hyphen)	
DRType	Dr. Specialty	Text	3	Use codes from below	
ServiceDate	Date of Service	Text	10	MM/DD/YYYY	
AdmitToERDate	Date Admitted to ER	Text	10	MM/DD/YYYY	
CptCode	CPT Code	Text	10		
CptClaimAmt	Amount claimed for this CPT	Text	9	999999.99	

SAN MATEO COUNTY EMS FUND
PHYSICIAN CERTIFICATION

I, Dr. ______________________, certify that, for each claim I submit for services rendered, I have provided the physician services listed on the claim(s) and have not received any compensation from the patient or any third party payor. I understand that I will be reimbursed by the EMS Fund for no more than 50% of San Mateo County's uniform fee schedule.

If I receive payment by the patient(s) or responsible payor(s) after I have received reimbursement from the EMS Fund, I shall notify the San Mateo County Health Services Agency. I understand that my future submission of claims to the EMS Fund will be reduced accordingly in the amount of payment(s) received from patient(s) or responsible payor(s).

I agree to keep and maintain patient(s) records for a period of 3 years from the date that my services were provided. As needed, the County may make an inspection and examination of my books and records during normal working hours pursuant to California Health and Safety Code Sections 1797.98a., 1797.98b and 1797.98c.

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

______________________	______________________	______________________
Signature of Physician	Physician's Specialty	Hospital(s) where services performed
______________________	______________________	______________________
Name of Physician (print)	Date Signed	Billing Agent