County of Ventura - Health Care Agency
EMSF/CHIP UNCOMPENSATED CARE PROGRAM

GENERAL RULES & CLAIMING GUIDELINES

[Note: This document is a general summary ONLY. The complete "EMSF/CHIP/TSF Policies and Procedures" and applicable law govern this program and must be referred to for full details. In the event of any inconsistency, the complete "Policies and Procedures" document will apply.]

I. GENERAL RULES

A. Allowable Gross Charges: Calculated by using CPT Codes, RBRVS unit values and Medicare Conversion Factors up to a maximum of 200**%** (effective July 1, 2000) of Medicare allowable for Ventura County; not to exceed billed charges.

B. Reimbursement: Maximum of 50% of Allowable Gross Charges, not to exceed billed amount; percentage may vary to be pro-rated according to the quarterly funding levels.

C. Payment Cycles: Checks will be issued quarterly; percentage of payment to be determined at the end of each fiscal quarter, based on funding levels and eligible claims received during that quarter.

D. Location: Services must be rendered in Ventura County.

II. CLAIM ELIGIBILITY

A. Submission Date: Claims must be submitted no earlier than 3 months, nor later than 120 days from the date of services following reasonable billing efforts to collect from patient and/or other payment sources (insurance, Medi-Cal, Medicare, etc.).

B. Forms: Claim must be submitted on a HCFA 1500 claim form, accompanied by a completed Uncompensated Care Program *Data Claim Form* and *Physician Services Acknowledgment Form* signed by the physician.

C. Eligible Services:

- **Emergency Medical Services Fund** (EMSF – Maddy) - Service provided by a physician for care rendered in an Emergency Room of a hospital located in Ventura County; and/or within 48 hours of admission to a hospital through the Emergency Room.

- **California Healthcare for Indigents Program** (CHIP) – for all nonemergent Obstetric services from the time of conception until ninety (90) days after the pregnancy ends; and Pediatric care provided to a patient under 21 years of age regardless of location (in office, hospital in-patient or out-patient); or meets EMSF eligibility criteria.

D. Exclusions: Claims determined to be Medi-Cal eligible will be denied. Medi-Cal eligibility screening will be conducted by Fund Administrator (AIA) monthly on all claims received. Denied claims will be immediately returned to physician with information for Medi-Cal submission.

E. Claim Rejection and Appeals:

- **Rejected claims:** Revised claims previously rejected for incomplete information must be received by the contracted Fund Administrator (AIA) within 20 calendar days from the date of the rejection letter.

- **Appeals:** Physician must submit an appeal of any denied claim within thirty (30) calendar days from the date of the denied Remittance Advice. Request from appeal may be submitted to the Physician Reimbursement Advisory Committee, a committee of physicians selected by the Ventura County Medical Association. Appeals shall include the CHIP Data Collection Form, HCFA 1500 Claim Form, and if applicable operative reports and other supporting documents as needed. Appeals shall be mailed to:

AIA/Ventura County EMSF/CHIP Claims
PO Box 2483
Bassett, CA 91746-0483

(800) 303-5242

Ventura County
Emergency Medical Services Fund
Uncompensated Care Program

Funding Levels & Submission Deadlines

- Program Available to All Physicians in Ventura County -

Funding Levels EMS Fund is currently approximately $2 million for each Fiscal year July 1st thru June 30th to reimburse physicians in Ventura County for the estimated $7 million in uncompensated care provided in Emergency Room Services and by OBG and Pediatric in office services.

New Claim and Acknowledgement forms are required effective 7/1/2001, and included in this packet. Please make copies for multiple claim submission. One Acknowledgement Form per batch, one claim form per claim.

Current Claim Submission Schedule

Fiscal Quarter	Date of Service	Submission Dates
1st	July August September	10/1 – 11/30 11/1 – 12/31 12/1 – 1/30
2nd	October November December	1/1 – 2/28 2/1 – 3/31 3/1 – 4/30
3rd	January February March	4/1 – 5/31 5/1 – 6/30 6/1 – 7/31
4th	April May June	7/1 – 8/31 8/1 – 9/30 9/1 – 10/31

TO AVOID REJECTION OF CLAIMS, PLEASE NOTE THE FOLLOWING WHEN SUBMITTING CLAIMS:

- **Data Form:**
  If unable to complete any part of patient info being requested, mark question "unknown".

  Items 19. – 24. must be completed in entirety, or claim will be rejected.

- **Do Not Submit Duplicate Claims:** A processing fee of $5.50 will be deducted from final claim payment, if duplicate claim is submitted.

COUNTY OF VENTURA - HEALTH CARE AGENCY

EMSF/CHIP
PHYSICIAN SERVICES ACKNOWLEDGEMENT FORM

SUBMIT TO: American Insurance Administrators (AIA)
Ventura County EMSF/CHIP Claims
PO Box 2483
Bassett, CA 91746-0483

The undersigned physician (hereinafter "physician") certifies that claims submitted hereunder are for medically necessary emergency services provided at a hospital and/or medically necessary inpatient or outpatient obstetric, or pediatric services provided to patients who cannot afford to pay, and for whom payment will not be made through any private coverage or by any program funded in whole or in part by the federal government. Physician acknowledges receipt of a copy of the "County of Ventura EMSF/CHIP Policies and Procedures" (hereinafter "Procedures"), promulgated by the County of Ventura, Health Care agency, the terms and conditions of which are incorporated herein by reference. Physician hereby agrees to abide by the terms and conditions of the Procedures for all claims submitted under this claiming process.

Physician agrees that all obligations and conditions stated in the Procedures will be observed by him/her, including, but not limited to, the proper refunding of monies to the County of Ventura when patient or third-party payments are made after reimbursement under this claiming process has been received; the cessation of current, and waiver of future, collection efforts upon receipt of payment; and the preparation, maintenance, and retention of service and finance records, including their availability for audit. Physician affirms that for all claims submitted, reasonable efforts to identify third-party payers have been made, no third-party payers have been discovered, and no payment has been received.

Physician expressly acknowledges and accepts that any County liability for claims submitted hereunder is at all times subject to the conditions defined in the Procedures, including, but not limited to, 1) availability of monies in the EMSF/CHIP Uncompensated Care Programs, 2) priority of claim receipt, and 3) audit and adjustments. In accordance with instructions in the Procedures, Physician agrees to submit required documents for claims, and provide other patient data as may be required by the County.

Physician certifies that information on claims submitted by him/her is true, accurate, and complete to the best of his/her knowledge.

_____
TYPE/PRINT NAME OF PHYSICIAN

_____ _____
PRIMARY SPECIALTY OF PHYSICIAN SIGNATURE OF PHYSICIAN

_____ _____
STATE LICENSE NUMBER DATE

**one form per batch of claims submitted*

COUNTY OF VENTURA - HEALTH CARE AGENCY

NON-COUNTY PHYSICIANS

DATA FORM - EMSF/CHIP/TSF UNCOMPENSATED CARE PROGRAMS

PATIENT INFORMATION *

COMPLETE ENTIRE CLAIM AND SUBMIT WITH HCFA-1500

1. SOCIAL SECURITY NUMBER: ☐☐☐ ☐☐ ☐☐☐☐

2. PATIENT'S NAME: _____
LAST FIRST MIDDLE INITIAL

(1) IF MINOR, PARENT/GUARDIAN: _____
LAST FIRST

3. PLACE OF BIRTH: _____
CITY STATE COUNTRY

4. MOTHER'S MAIDEN NAME: _____

5. ETHNICITY: (CHECK ONE)
☐ (1) WHITE
☐ (2) BLACK
☐ (3) ASIAN/PACIFIC ISLANDER
☐ (4) NATIVE AMERICAN/ESKIMO/ALEUT
☐ (5) HISPANIC
☐ (6) FILIPINO
☐ (7) OTHER

6. EMPLOYMENT TYPE:
☐ (0) UNEMPLOYED
☐ (1) FARMING/FORESTRY/FISHING
☐ (2) LABORERS/HELPERS/CRAFT/ INSPECTION/REPAIR/PRODUCTION/ TRANSPORTATION
☐ (3) SALES/SERVICE
☐ (4) EXECUTIVE/ADMINISTRATIVE/MANAGER/ PROFESSIONAL/TECHNICAL/RELATED SUPPORT
☐ (5) OTHER

7. MONTHLY INCOME: $ _____ 8. FAMILY SIZE (COUNT PATIENT AS 1): _____

SOURCE OF INCOME:
☐ (0) NONE
☐ (1) GENERAL RELIEF
☐ (2) WAGES
☐ (3) SELF-EMPLOYED
☐ (4) DISABILITY
☐ (5) RETIRED
☐ (6) OTHER, e.g., UNEMPLOYMENT/VA BENEFITS/INTEREST/DIVIDENDS/RENT/ CHILD SUPPORT/ALIMONY, ETC.

PATIENT INFORMATION VERIFICATION

* IF UNABLE TO OBTAIN INFORMATION FROM HOSPITAL, SUBMITTING PHYSICIAN/AGENCY MUST GIVE REASON(S) WHY INFORMATION WAS NOT OBTAINED AND MUST SIGN INDICATING EVERY ATTEMPT WAS MADE:

REASON (S): _____

SIGNATURE: _____

PHYSICIAN SERVICES

19. PHYSICIAN FUND -- (*CHECK ONE BOX ONLY*): Use a separate Data Claim Form for each Physician Fund area below.
☐ (1) NON-CONTRACT EMERGENCY
☐ (2) PEDIATRICS
☐ (3) OBSTETRICS EDD: ☐☐☐
☐ (4) BEYOND 48 HOURS
Must provide following info on intial ER encounter:
Date: _____ Provider: _____

20. SERVICE SETTING:
☐ (1) INPATIENT
☐ (2) EMERGENCY DEPARTMENT
☐ (3) OUTPATIENT/OFFICE VISIT (CHECK ONE): ☐ a. PRIMARY CARE ☐ b. SPECIALTY CARE

21. PHYSICIAN'S NAME: _____ STATE LICENSE NO: _____

22. PAYEE NAME: _____ PAYEE TAX ID#: _____

PAYEE ADDRESS: _____

23. DATE BILLED EMSF: ☐☐☐ CHARGES: $ _____

FOR QUESTIONS REGARDING CLAIM:

24. CONTACT PERSON _____ TELEPHONE NO: ( ) _____