	COUNTY OF SACRAMENTO EMERGENCY MEDICAL SERVICES AGENCY	Document #	1103
	Maddy Emergency Medical Services (EMS) Fund **Physician Emergency Medical Services (PEMS) Guidelines**		

I. Purpose

To define the guidelines for disbursement of the Maddy EMS Fund for Physician Emergency Medical Services (PEMS).

II. Background:

A. In 1987, the Legislature enacted Senate Bill (SB) 12 allowing each county to establish, finance, and administer a Maddy Emergency Medical Services (EMS) Fund. It is named after the the bill's author, Ken Maddy. It was subsequently amended in 1988 (SB 612, Maddy) to create a penalty assessment of two (2) dollars out of every ten (10) dollars that is levied on applicable vehicle code fines, penalties, and forfeitures (Government Code Section 76000). Deposits into the Maddy EMS Fund are made monthly by the courts.

B. In 2007, the Legislature enacted SB 1773 (Richie's Fund) allowing each count to assess an additional penalty in the amount of two (2) dollars for every ten (10) dollars upon applicable vehicle code fines (Government Code Section 76000.5). The additional revenues to be deposited into a county's Maddy EMS Fund to support local emergency medical services agencies, trauma services, uncompensated emergency care, and pediatric care.

C. SB 12 and all its amendments and SB 1773 refer to the Health and Safety Code, Section 1797.98a(b)(A) that establishes and governs the distribution of fifty-eight percent (58%) of ninety percent (90%) of the Maddy EMS Fund for physicians and the conditions under which physicians may claim for uncompensated emergency services.

D. The funds are intended to reimburse emergency physicians, including on-call physician specialists, providing emergency medical consultations and/or treatment to nonpaying patients on the calendar day on which emergency medical services is first provided and on the immediately following two (2) calendar days.

III. Authority:

A. California Health and Safety Code, Division 2.5, Sections 1797.98a-1797.98g

B. Welfare and Institutions Code, Sections 16951-16959

C. Government Code Sections 76000 and 76000.5

D. Sacramento County Code, Chapter 6.105

IV. Definitions

A. Emergency Services – Physician services provided to a patient experiencing an emergency medical condition in an acute care hospital licensed to provide basic or comprehensive emergency services.

B. Emergency Medical Condition – 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:

1. Placing the patient's health in serious jeopardy.
2. Serious impairment to bodily functions.
3. Serious dysfunction to any bodily organ or part.

C. Medical Screening Exam – Is an 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.

D. Stabilized - is the point at which the patient is deemed to no longer require emergency medical services and care. A patient is deemed to no longer require emergency services after the end of the calendar day (midnight) following the calendar day in which the patient presented his or herself for emergency treatment.

V. Overview

A. Providers with unpaid claims for emergency obstetric/pediatric and emergency department services may, subject to claiming requirements and after the passage of the specified waiting period as defined below, submit claims quarterly for partial reimbursement.

B. At the end of the specified submission period, claims are processed in accordance with the guidelines listed below.

C. Claims shall be deemed filed on the date on which they are entered into Advanced Medical Management (AMM)'s approved clearinghouse(s).

VI. Claiming Procedure:

A. Eligible Services

1. Emergency services provided by physicians and surgeons, except those physicians and surgeons employed by county hospitals, up to the point that the patient is stabilized in:
    a. General acute care hospitals that provide basic or comprehensive emergency services.
    b. A site that was approved by the County prior to January 1, 1990, as a paramedic receiving station for the treatment of emergency patients.
    c. A standby emergency department that was in existence on January 1, 1989.
2. Services are eligible only if they are delivered on the date of initial medical screening and the following consecutive two (2) calendar days:
    a. If a patient must be transferred to another facility for a higher level of treatment, services delivered on the date of transfer and next consecutive two (2) calendar days are eligible.
3. Medical screening examinations required by law to determine whether an emergency exists notwithstanding a determination after the examination that a medical emergency does not exist.

4. Inpatient and outpatient obstetric services which are medically necessary, as determined by the attending physician.
5. Inpatient and outpatient pediatric services which are medically necessary, as determined by the attending physician.
6. Emergency, obstetric, and pediatric services provided by, or in conjunction with, a properly credentialed nurse practitioner or physician's assistant rendered under the direct supervision of a physician or surgeon who is present in the facility where the patient is being treated and who is available for immediate consultation.
7. Emergency obstetric or pediatric services which had no payments from any source.

B. Eligible Patients
   1. Patients who do not have medical coverage for emergency services.
   2. Patients who cannot afford to pay for their services.
   3. Patients without a responsible third party from which payment is forthcoming.
   4. Patients not covered by any program that receives federal funding, with the exception of Section 1011 of the Federal Medicare Prescription Drug Improvement and Modernization Act of 2003.

C. Eligible Physicians and Surgeons
   1. Physicians and surgeons who for each claim submitted have done the following:
      a. Inquired if the patient has medical insurance for emergency services.
      b. Inquired if there is a third party source of payment.
      c. Billed for payment of services by either of the following:
         i. Waited at least three (3) months from the date of billing the patient or third party, during which time they have made at least two (2) attempts to obtain payment and have received no reimbursement for any portion of the amount billed.
         ii. Received actual notification from the patient or third party that no payment will be made for the services rendered.
      d. Stopped all current and waived any future collection efforts to obtain reimbursement from the patient, upon receipt of money from the Maddy EMS Fund.

VII. Procedure for Submission of Quarterly Claims

Effective October 1, 2018, the PEMS program will no longer accept paper claims. Claims will be submitted electronically to Advanced Medical Management's approved clearinghouse for review, validation, and approval prior to payment.

A. Enroll with Advanced Medical Management's approved clearinghouse(s) for electronic claims submission. All claims must be submitted electronically through Office Ally. Physicians may refer to the PEMS Provider Operations Manual for additional instructions on electronic claims submission.

Office Ally - www.officeally.com.
Customer Support: 866-575-4120
Payer ID #: AMM22

* If you have questions related to electronic claims submission, please contact:

AMM Claims Operations Manager
Rachel Miller
562-766-2000 Ext. 231
racosta@amm.cc

B. Acceptable Submission Formats:

- Electronic ANSI 5010 837 professional claim transaction

C. Register with Advanced Medical Management's Claims Manager portal at https://claims.amm.cc to check on claim status and access the Explanation of Benefits (EOBs).

VIII. Account Administration and Reimbursement

A. Payments

1. No disbursement shall be made on any claim filed on or after October 1, 1990 which is not in the name of and made by either:
   a. An individual physician or physician and surgeon;
   b. A Physician Group, but only in amounts for and in behalf of individual physicians or surgeons who have signed and filed written assignments per the Physician Certification Form.
   c. Hospitals, pursuant to and under the authority conferred by Health and Safety Code Division 2.5, Sections 1797.98a-1797.98g and Welfare and Institutions Code Sections 16951-16959.

B. Reimbursement Guidelines

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 up to fifty percent (50%) of the current Medi-Cal Fee for Service rate as published by the California Department of Health Care Services for services provided. Reimbursement is contingent upon the availability of moneys 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. 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 identified submission timeline for that quarter.
6. If a physician receives a payment from a patient or responsible third-party for services that were reimbursed by Maddy EMS Fund, the physician will notify AMM 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 payer, but not more than the amount of reimbursement received from the fund for care of that patient (checks should be made to "Sacramento County EMS Agency"): or
    b. Elect to have the fund reduce payment on a future claim by the amount collected from the patient or other payer, 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 payer, the physician must make a refund as stated in the previous paragraph.

C. Appeals

1. Providers have the right to appeal on any matter relating to disbursement.
    a. To appeal the provider must, within fifteen (15) business days of receiving a notice of a denied or rejected claim, appeal in writing to the designee at the address located in the notice.
    b. The appeal shall contain the specific reason for the appeal.
    c. Physicians receiving claims denied or 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 in writing to AMM.
    d. All appeals should be mailed to:

        Sacramento County PEMS – Advanced Medical Management, Inc.
        Attn: Claims Appeals
        5000 Airport Plaza Drive, Suite 150
        Long Beach, CA 90815-1260

D. Records

1. 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.
2. Physicians determined to have knowingly submitted false claims for reimbursement may be reported to the District Attorney's Office for possible prosecution for civil fraud.
3. Providers will maintain, and make available for audit by the State of California or Sacramento County Department of Health Services (DHS) for a period of at least three (3) years from the date of service the following records:
    a. Original medical records.
    b. Special Note: For services delivered by or in conjunction with a physician's assistant or nurse practitioner, provider shall for three (3) years maintain: A medical record that has been reviewed and countersigned by the supervising physician or surgeon who was present in the facility where the patient received services and available immediately for consultation, in accordance with regulations established for the supervision of nurse practitioners and physician assistants in California.
    c. Documentation of required patient insurance and third-party inquiries.
    d. Documentation of billing efforts.
    e. Documentation, if applicable, of patient communication that no payment will be made.
    f. Documentation of submission to Maddy EMS Fund.

E. With reasonable notice, the Department of Health Services Fiscal unit 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.

F. Provider Right of Review

1. All non-confidential records relating to disbursement, methodology, policy, and procedure are available for your inspection and review. A written request must be sent to the address listed in the "Contacting Us" section.

G. Contact Information

1. Claim Submittal, Processing and Disbursement

    Claims may be submitted to AMM via Office Ally using the information detailed below. If you need assistance regarding electronic claims submission, please contact:

AMM Claims Operations Manager
Rachel Miller
562-766-2000 Ext. 231
racosta@amm.cc

2. Refunds:

   ATTN: DHS Fiscal
   7001-A East Parkway Suite 1100
   Sacramento, CA 95823

References:

EMS P&P # 1101: Maddy EMS Fund: Overview
EMS P&P # 1102: Maddy EMS Fund: Trauma Hospital Distribution Guidelines
County Ordinance 6.105: The Maddy Emergency Medical Services (EMS) Fund

SACRAMENTO COUNTY EMERGENCY MEDICAL SERVICES AGENCY (SCEMSA)
MADDY EMS FUND DISTRIBUTION

FISCAL YEAR QUARTER	PATIENT DATE OF SERVICE	REQUIRED COLLECTION PERIOD	CLAIM SUBMITTAL (Immediately following the required minimum collection period efforts)	DISTRIBUTION
FIRST	JUL 1- 31 AUG 1-31 SEP 1-30	1. A period of not less than 3 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.	OCT - DEC NOV - DEC DEC	END OF JANUARY
SECOND	OCT 1-31 NOV 1-30 DEC 1-31		JAN - MAR FEB - MAR MAR	END OF APRIL
THIRD	JAN 1-31 FEB 1-28 MAR 1-31		APR - JUN MAY - JUN JUN	END OF JULY
FOURTH	APR 1-30 MAY 1-31 JUN 1-30		JUL - SEP AUG - SEP SEP	END OF OCTOBER

** 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.*