Winter/Spring 1995 Bulletin No. 7

COUNTY OF LOS ANGELES/DEPARTMENT OF HEALTH SERVICES (DHS)

PHYSICIAN REIMBURSEMENT PROGRAM

Information Bulletin

"THE CHECK IS IN THE MAIL!!"

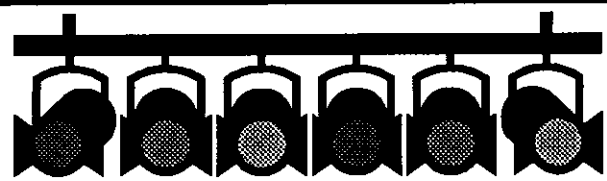
FY 93/94 RAISE UP

As previously described in the Fall 1994 Information Bulletin, the submission of claims for fiscal year (FY) 93/94 continued to be low through the December deadline. Nearly 75,000 fewer physician claims were submitted in FY 93/94 as compared to FY 92/93. As a result, physicians who billed the Physician Services for Indigents (PSIP) and/or Trauma Funds will receive raise ups:

Fund	*Initial %*	*Final %*	*Raise Up %*
PSIP Fund	30%	50%	20%
Trauma Fund	65%	75%	10%

All PSIP claims processed on or after January 27, 1995 were adjudicated at the 50% rate and all Trauma claims processed on or after March 3, 1995 were adjudicated at 75%. For claims adjudicated prior to these dates, it is anticipated that raise up warrants will be mailed in May. A single payment will be made to each provider based on previous claims submitted and paid.

The decrease in submission of claims may be attributed to several things: 1) the elimination of payment of claims for the General Relief recipients and 2) the new Point of Service capability provided through Medi-Cal. In addition, statistics show that due to aggressive trauma prevention programs, the rate of trauma is generally down across the county.



Highlights of FY 94/95 Program

> Enrollment packets for FY 94/95 PSIP and Trauma CHIP programs have been mailed to all physicians. **Claims are now being accepted.** If you have not received a packet, contact American Insurance Administrators (AIA) at:

Physician Hotline 1 (800) 303-5242

> **SUBMISSION DEADLINE MOVED UP:** All claims for the period of July 1, 1994 to June 30, 1995 (FY 94/95) must be postmarked no later than November 30, 1995. This is one month earlier than previous years.

> Enrollment Forms and Conditions of Participation must be complete for **each program year** as they are considered new contracts. If a physician bills for Trauma and PSIP, both forms must be completed for each program.

> REIMBURSEMENT RATES: The initial reimbursement rate for the PSIP program will remain at 30%, whereas the Trauma program is increased to 70%. The OB-Call Back program has been eliminated.

> ADDITION TO TRAUMA PROGRAM: Emergency Department (ED) physicians treating trauma patients at a trauma hospital will be reimbursed at the trauma rate (70%). This applies only to patients meeting the criteria for entry into the trauma registry. ED physicians who need a trauma packet should contact AIA at the hotline number listed above.

Multiple Surgical Procedures

For bills claiming multiple surgical procedure codes, documentation must include the operative report. For emergent gall bladder procedures, a pathology report is also required.

Fiscal Year 1994-95 claims of service will be adjudicated according to reimbursement guidelines which have been adopted by HCFA's 1995 Medicare fee schedule and approved by the Physician Reimbursement Advisory Committee (PRAC).

Procedure Number	Fee Schedule
1st Procedure	100%
2nd Procedure	50%
3rd Procedure	50%
4th Procedure	50%
5th Procedure	50%

FLASH!!!

Where are your FY 94-95 claims???

Avoid the rush and submit ASAP.

TO:

American Insurance Administrators

Box 34759

Los Angeles, CA 90034-0759

MEDI-CAL ISSUES

■NON-EMERGENCY CLAIMS:

Claims denied by Medi-Cal because they were not emergencies are not eligible for consideration under this program.

■PENDING CLAIMS:

Claims that are pending Medi-Cal approval are not considered eligible for this program.

■E.O.B. ADJUSTMENTS:

Claims adjusted by Medi-Cal are not eligible for payment under this program.

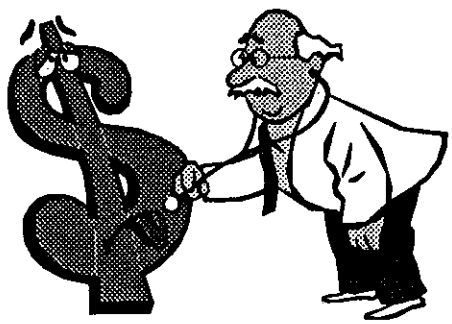
■SHARE OF COST:

Any claims denied for "Share of Cost" are not eligible for CHIP program funding.

■DEADLINE DENIAL:

If Medi-Cal denies the claim because it is submitted past the deadline, the claim cannot be resubmitted to the CHIP program.

LIMITED 3RD PARTY INSURANCE



If a patient has a limited 3rd party insurance (i.e., automobile or sports insurance) and the medical benefits have been exhausted by another health care provider, usually the hospital, reimbursement will be considered only on an appeal basis.

The appeal must include a letter from the insurance company denying benefits because they have been exhausted. For complete instructions on the Appeals Procedure, please refer to the FY 94/95 Physician Reimbursement Policies, page 3, section VI.