Summer 1999 Bulletin No. 10

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

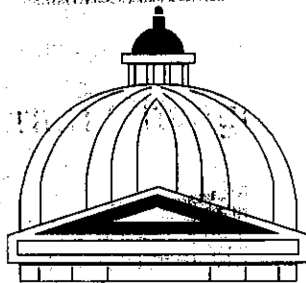
PHYSICIAN REIMBURSEMENT PROGRAM

Information Bulletin

GOVERNOR'S PROPOSED REDUCTIONS

The Governor's budget for the balance of 1998/99 proposes reductions of 11% in the County's Prop 99 Non-County Hospital Account and 3% in the Physician Account. The Proposed budget for 1999/2000 contains even more dramatic cuts, particularly in the Physician Account, roughly a 41% proposed reduction (see projection in the table below).

The Hospital and Physician Accounts are restricted to the private sector, primarily for emergency, trauma, obstetric and pediatric care. These two accounts are further split evenly within each account to allow 50% of each account to be used at County discretion in accordance with statutes. Since these funds became available in early 1990, the Board of Supervisors has routinely appropriated its discretionary hospital and physician funds to **private sector trauma hospitals and physicians.**



The 1990 infusion of Prop 99 funds for indigent care stabilized the trauma system. Unless funding, particularly physician funding, is restored or replaced by some other funding source, it is predicted the trauma system may collapse.

This information is now being discussed in many local and state committees and among hospitals, physicians and the State EMS Authority.

FY 1998-99 TRAUMA PACKETS MAILED OUT

On June 2, 1999, the Board of Supervisors approved the continuation of the Trauma Physician Services Program. The Trauma payments will continue to be made at 75% of the Official County Finance Schedule (OCFS) for FY 1998/99. An eligible "Trauma" patient seen at a designated trauma hospital requires a Trauma Patient Sequence (TPS) number. Claims received without a TPS number will be reimbursed at 50% of the OCFS under the PSIP Program. Claims with an inaccurate or invalid TPS number will be rejected until accurate information is submitted.

Trauma packets have been mailed to all formerly enrolled trauma physicians. If you know of new physicians who are eligible for this program, please direct them to:

American Insurance Administrators
1-(800)-303-5242

PHYSICIAN PROGRAM AUDITS

The Department of Health Services continues to randomly audit individual physician billing practices. If it is determined that a physician is inappropriately billing the CHIP program, the physician may be excluded from future participation and or be required to refund the program.

(*Continued on reverse side*)

Non-County Physicians		($130,000 reduction*)	($2,184,730 reduction*)
EMS Physician Services	$2,649,000	$2,584,000	$1,556,653
Trauma Physician Services	$2,649,000	$2,584,000	$1,556,653
Total	$5,298,000	$5,168,000	$3,113,270
		3% reduction	**41% reduction**

*Divided between accounts
Notes: This does not include EMS Funds (SB12/612)

PHYSICIAN PROGRAM AUDITS

(*continued from page 1*)

Inappropriate billing may include such practices as failure to seek 3rd party payment prior to billing the CHIP program or failure to refund CHIP payment to the County following 3rd party payment.

In a past audit, it was determined that a physician provider submitted multiple billings of insurance, Medi-Cal and other sources at the same time as billing the CHIP program. Such practices are not in keeping with the program's Conditions of Participation and Billing Instructions and could jeopardize the provider's future participation. Another audit exception is failure to provide documentation of billed procedures and incorrect billing codes as well as duplicate Evaluation and Management (E&M) coding.

FY 98/99 Program Changes

- Blood Transfusions

  Cpt-4 Code 36430, Transfusion of Blood and Blood Components (venous), will no longer require a TAR.

- Neonatal Intensive Care

  Neonatal code 99295 can be used for NICU babies only if the claim is accompanied with documentation, including a statement of how the hospital received payment and supporting medical records. If the required documentation is not received, codes will be down graded to a hospital care visit code.

- Consultant Codes

  Outpatient Consultation Codes 99241-99245 may be used and will be paid for patients seen in the ED on consultation. Proper utilization of these codes will be continually monitored be the Physician Reimbursement Advisory Committee (PRAC).

REMINDERS AND UPDATES

- **E and M Codes**

  Only one E & M series code will be paid. If two E & M codes are billed, the highest unit code will be processed. For example, a billing for 99245 and 99291 on the same day will result in payment of 99291 at 5.54 units compared to 99245 at 6.28. In rare cases where two E&M codes actually apply, written justification must be provided.

- **Place of Service**

  The place of service must match the codes. For example, you cannot use an ED services code like 99282 for an inpatient.

- **F.P.A. Billings**

  Some physicians have attempted to bill the PSIP program for F.P.A. non-payments. The PSIP program will not pay for these services. F.P.A. billings are not being "denied" by the F.P.A. and its affiliates but are being held since F.P.A. has filed for protection under the bankruptcy laws. Once the bankruptcy decisions are made, some percentage of payment, yet to be determined, will be made. In addition, the California Medical Association is filling a class action suit against the officers For addition information, you are encouraged to contact Elizabeth McNeil in the CMA's San Francisco Office at (415) 882-3376.

Claims submission Deadline is November 30, 1999

All claims for the Physician Reimbursement Program are to be mailed to:

American Insurance Administrators
P.O. Box 34759
Los Angeles, Ca.
90034-0759