

TRAUMA CENTER FINANCIAL WORKSHOP

FREQUENTLY ASKED QUESTIONS AND CONTRACT REQUIREMENTS

1. **Who is eligible for this program?** Only patients who are unable to pay for services and for whom there is no third-party coverage in part or in whole for trauma services provided qualify under this funding program. **No reimbursement shall be provided for patient care if the patient has the ability to pay for the service, but refuses or fails to pay for same.**
REFERENCE: EXHIBIT B PAGE 1

2. **When can I bill the program?** To bill County, Contractor must at a minimum show that it has made reasonable efforts to secure payment for the patient by billing (at least monthly) for an additional period of not less than two (2) months after the date Contractor first billed the patient.
REFERENCE: EXHIBIT B PAGE 2

3. **What documents do I have to submit to bill the program?**

A completed **Original** CHIP form (Attachment B-4)*

A completed **Original** UB-92 form (Attachment B-4)*

A **copy** of the completed TSCE form (Attachment U-1)

or

A **copy** of the completed Inability to Cooperate form (Attachment U-2)

*Hospitals must ensure that all data elements from the CHIP and UB-92 match the data elements from TEMIS. Reimbursement by County shall only be made on claims for which all required documentation matches TEMIS.

REFERENCE: EXHIBIT B PAGES 3&4

4. **When can an Inability to Cooperate Form (U-2) be submitted?** If a TSCE Agreement form cannot be secured because the patient or the patient's responsible relative (s) is (are) unable to cooperate in providing the necessary financial information, then a Contractor certification to that effect (Attachment "U-2", Hospital Certification of Inability to cooperate form) must be completed. Examples of these situations include, but are not necessarily limited to, situations where the patient has expired, or is comatose or otherwise mentally incompetent.
REFERENCE: EXHIBIT B PAGES 3&4

5. **What is the difference between Cash/Self and CHIP Eligible?**

There is no difference as far as reimbursement goes. They are defined in the Trauma Data Dictionary as follows:

Cash/Self: Individuals who are not insured and do not qualify for other funding source based on ability to pay in accordance with the hospital's charity care policy, as determined by the hospital's finance department. For County facilities this includes ATP (Ability to Pay).

Chip Eligible: Individuals who qualify for California Healthcare for Indigents Program which provides limited funds to compensate for patients who cannot afford to pay for services rendered and for whom payment will not be made through any private coverage or by any program funded in whole or in part by the State or Federal government including Medi-Cal or Victims of Crime.

Some Trauma Centers use both they enter either CHIP or Cash as the first payer, or use only Cash and some use only CHIP. Claims submitted are reimbursed if TEMIS has either CASH/Self or CHIP Eligible in any combination. Technically, all patients for whom claims are submitted should have CHIP Eligible as either the first or 2nd payer, but as long as no other payer is in TEMIS, the County will pay.

- 6. What are the policies on refunding the County if the hospital receives payment from a patient or third party payer for claims previously paid by the County?** Any and all payments received by the Contractor must immediately be reported and the County's payment must be refunded. Each refund should have a Trauma Hospital Payment Refund Form (Attachment B-6) attached.
REFERENCE: EXHIBIT B PAGE 8
- 7. What if the hospital has submitted a claim and payment has not been issued by the County, but Contractor is informed that there is Third Party Liability (TPL)?** Contractor must pursue the TPL and withdraw the claim by notifying the County indicating that there is pending TPL to the EMS Agency Reimbursement Coordinator at (562) 347-1590.
REFERENCE: EXHIBIT B PAGES 8 & 9
- 8. Must the hospital continue to pursue third party payer coverage after the claim has been submitted to the County for Reimbursement?**
Yes. The Contractor shall pursue reimbursement from third party coverage such as Medi-Cal, Medicare, other government programs, or other health insurance if they become aware of coverage. Contractor shall upon verification of such third party coverage, submit a bill for its services to the third party. As soon as payment is received, Contractor shall reimburse County any payment received under the Trauma Center Service Agreement (TSCA) for that patient.
REFERENCE: EXHIBIT B PAGE 9
- 9. What are the procedures if a provider is contacted by a third party representative (e.g., insurance claim adjuster) or a patient's attorney regarding pending litigation for a previously paid claim?** Contractor shall indicate that the claim for services provided to their client is assigned and subrogated to the County and refer such representatives to the designated County contact. (Contractor shall reasonably cooperate with County in its collection efforts).
REFERENCE: EXHIBIT B PAGE 10
- 10. What rates would the Contractor be paid if patient is admitted (i.e. on June 29th and discharged on July 5th)?** This claim would be part of the fiscal year that ended in June. Payment by County to Contractor for such patients shall be at the rates in effect on the date

11. **Can a claim be submitted if there is pending TPL?** Yes, but these claims should not be submitted until the October 31st deadline nears. These claims may not be paid but will be counted towards the Medi-Cal match total.
12. **Who is considered the last resort of payment, the County or Victims of Crime (VOC)?** Victims of Crime is considered the last resort of payment.
REFERENCE: ATTACHED VOC LETTER
13. **Can a provider bill both the VOC and the Trauma Reimbursement Program?** At any point during the claiming period, the hospital has a choice of the following:

Submit the claim to VOC and DO NOT SUBMIT to the County
Submit the claim to the County and DO NOT SUBMIT to VOC
REFERENCE: ATTACHED VOC LETTER
14. **What if a payment is received from a third party payer and they are offering less than what the County reimbursed? Can I refuse to take their payment?** No. You must immediately notify the County and refund the County's payment.
15. **Are in-custody patients covered by this program?** No, If the patient is in-custody before or during hospitalization, they are not eligible. (The key is the status while hospitalized).
16. **What is the basis for number of hospital days reimbursed?**
The number of hospital days paid will be based upon the number of hospital day room charges on the UB-92, but shall not exceed the number of days calculated between admission and discharge dates. **Claims which include hospital day room charges on the UB-92 that exceed the calculated number of days between hospital admission and discharge will be returned for correction.**