Agenda Item #: 3S-2

PALM BEACH COUNTY
BOARD OF COUNTY COMMISSIONERS

AGENDA ITEM SUMMARY

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Meeting Date: July 7, 2009 [X] Consent [ ] Regular
[ ] Workshop [ ] Public Hearing

Department

Submitted For: FIRE RESCUE

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I. EXECUTIVE BRIEF

Motion and Title:

Staff recommends motion to:

A) approve the U.S. Department of Labor Provider Enrollment Form; and

(B) **authorize** the County Administrator or his designee (Fire-Rescue Administrator) to execute the U.S. Department of Labor Provider Enrollment Form on behalf of the Board of County Commissioners.

Summary:

The U.S. Department of Labor, Employment Standards Administration, Office of Workers' Compensation Programs (OWCP) administers the Federal Employees' Compensation Act, the Coal Mine Workers' Compensation program, the Energy Employees Occupational Illness Compensation Program and the Longshore and Harbor Workers' Compensation Program. As part of their benefit structure, these four programs reimburse both, medical and non-medical providers for services rendered for the care and treatment of a claimant's compensable condition. OWCP contracted with Affiliated Computer Services (ACS) to provide medical bill processing services to the four programs. To process claims submitted by the County for emergency transport services, the U.S. Department of Labor is requiring service providers be enrolled with ACS.

Countywide (SB)

Background and Policy Issues:

Since 1995, Palm Beach County Fire-Rescue has been transporting patients to emergency facilities and using a third-party billing agent to process claims for reimbursement from Medicare, Medicaid, commercial insurance and self-pay sources. Providers seeking reimbursement from the U.S. Department of Labor, for services rendered to patients eligible for benefits under the OWCP programs, are required to complete a Provider Enrollment Form before payment can be issued. ACS is holding payment for service to Providers who do not have a current Provider Agreement on file.

Attachments:

1. US Department of Labor, Employment Standards Administration, Office of Workers' Compensation Programs, Provider Enrollment Form

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Recommended By: _____ 6-17-09
Deputy Chief — Date

Approved By: _____ 6-17-09
Fire-Rescue Administrator — Date

II. FISCAL IMPACT ANALYSIS

A. Five Year Summary of Fiscal Impact:

Fiscal Years	2009	2010	2011	2011	2012
Capital Expenditures					
Operating Costs					
External Revenues					
Program Income (County)					
In-Kind Match (County)					
NET FISCAL IMPACT	* See below				
# ADDITIONAL FTE POSITIONS (Cumulative)					

Is Item Included in Current Budget? Yes_____ No____

Budget Account No.: Fund ____ Dept____ Unit_____Object_____

B. **Recommended Sources of Funds/Summary of Fiscal Impact:**

There is no fiscal impact associated with the approval of this Provider Enrollment Agreement.

C. **Departmental Fiscal Review:** _____

III. REVIEW COMMENTS

A. **OFMB Fiscal and/or Contract Dev. and Control Comments:**

* The Net Fiscal Impact associated with this item is indeterminable at this time.

6/24/09
OFMB 6/23/09 6/19/09

6/25/09
Contract Dev. and Control

B. **Legal Sufficiency:**

6/26/09
Assistant County Attorney

C. **Other Department Review:**

Department Director

THIS SUMMARY IS NOT TO BE USED AS A BASIS FOR PAYMENT.

A C S
Fiscal Agent Service
PO Box 14600
Tallahassee, FL 32317-4600

U.S. Department of Labor
Employment Standards Administration
Office of Workers' Compensation Programs

September 10, 2003

Dear Provider:

Thank you for your participation as a provider for the U.S. Department of Labor, Office of Workers' Compensation Programs (OWCP).

The OWCP administers the Federal Employees' Compensation Act (FECA), the Coal Mine Workers' Compensation Program (DCMWC), the Energy Employees Occupational Illness Compensation Program (EEOICPA) and the Longshore and Harbor Workers' Compensation Program (LSHWC). As part of their benefit structure, these four programs reimburse both, medical and non-medical providers for services rendered for the care and treatment of a claimant's compensable condition.

OWCP has contracted with Affiliated Computer Services (ACS) to provide medical bill processing services to the four programs. Each program will be phased in over the next two years beginning with the Federal Employees' Compensation program later this year. Providers of services to DFEC should continue to bill the program at the London, Kentucky address listed below. Providers of services to the other OWCP programs should continue sending bills directly to those programs.

To process your bills, each provider MUST BE ENROLLED with ACS. Please complete the enclosed provider enrollment form so that a provider I.D. number can be assigned to you. **Effective July 26, 1996 the Debt Collection Improvement Act of 1996 MANDATES that payments made by the Federal Government be sent by electronic funds transfer (EFT) therefore, an enrollment form for EFT is also enclosed. A Remittance Advice listing all bills paid on each EFT transaction will continue to be sent to your mailing address.**

In addition to the provider and EFT enrollment forms enclosed are instructions for completing the enrollment form, a list of provider types, a list of provider specialty codes and an Electronic Data Interchange (EDI) form should you choose to bill electronically.

Please send the completed package to:

Affiliated Computer Services (ACS)
Enrollment Unit
Department of Labor
PO Box 14600
Tallahassee, FL 32317-4600

If you are a physician, you MUST submit copy of your license along with the enrollment application.

Once your enrollment package has been processed, you will be notified by mail in approximately two weeks. During the transitional period, please continue to submit your bills to:

US Department of Labor
OWCP
PO Box 8300
London, KY 40742-8300

Please do not hesitate to contact our toll-free number at 1-866-335-8319 Monday through Friday from 8:00 am to 8:00 pm Eastern Standard Time, if you have any questions on this material.

Provider Enrollment Form

U.S. Department of Labor
Employment Standards Administration
Office of Workers' Compensation Programs

OMB Number 1215-0137
Expires: 03/31/2010

Please refer to instructions for completing this form.

Provider Number	Effective Date
	FOR DOL USE ONLY

1. Are you applying for a new enrollment or updating your record? If update, enter Provider Number or EIN: [XX] New enrollment [ ] Update

2. What is the earliest date that you treated a participant in any OWCP program? 06/01/07

Practice Information

3. Practice Name	4. Address		
Palm Beach County (Fire Rescue)	405 Pike Road		
5. City		6. State	7. Zip (9 digits)
West Palm Beach,		Florida	33411
8. Telephone		9. FAX	
(866) 622-5104		(305) 459-0601	

10. Type of Practice a. [XX] Individual b. [ ] facility (For Individual or Facility, complete indicated sections below)
c. [ ] Group (Please see reverse for completion of group enrollment)

Provider Type (Individual or Facility)

11a. Provider Type Number	11b. Provider Type
40	Ambulance

11c. If you select "Other Provider" (96) or Non-Medical Vendor (53), please explain:

12. Tax ID: EIN	SSN
59 59-6000785	

13. Required for hospitals only:	13a. Medicare Number
13b. NPI: 1. 1962412072	13c. Taxonomy Code(s): 1.
2.	2.
3.	3.

License and Certification (Individual for M.D. and D.O. only)

14a. Name	14b. License #/ State	14c. Current Lic Expiration Date	14d. Specialty Code(s)	14e. Certification Expiration Date

15. United Mine Workers' of American (UMWA) Number, if applicable:

Billing Address-indicate "same" if identical to Practice Address.

16a. Address			
PO BOX 862036			
16b. City		16c. State	16d. Zip (9 digits)
ORLANDO		FLORIDA	32886

17. [ ] I have completed a form for Electronic Funds Transfer (EFT).

18. [ ] I am interested in billing electronically

NOTICE: Anyone who misrepresents or falsifies essential information to receive payment from Federal funds may upon conviction be subject to fine and imprisonment under applicable Federal laws.

Signature (Provider or Representative and Title)	Date

Form OWCP-1168
Rev. June 2006

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Group Provider Enrollment - #10c

For group practice enrollment, please enter the following information for **each professional** who will provide services under the group EIN. Select from the attached list the Provider Type code that most closely describes the service(s) that the professional provides. Attach separate sheet for additional entries if necessary.

Name	SSN #	Prov Type Code	License #/ State	Current Lic# Exp Date	Specialty Code(s)	Certification Exp Date

Please return this completed form to the appropriate program at the following address to prevent a delay in the processing of your bills.

For Federal Employees' Compensation Act (FECA) Program:	*For Black Lung Program:*	*For Energy Program:*
ACS P.O. Box 14600 Tallahassee, FL 32317-4600	DOL Black Lung Program P.O. Box 13200 Tallahassee, FL 32317-3200	DOL Energy Program P.O. Box 13400 Tallahassee, FL 32317-3400
If you have any questions regarding the completion of the form, please call Toll Free: 1-866-335-8319	If you have any questions regarding the completion of the form, please call Toll Free: 1-800-638-7072	If you have any questions regarding the completion of the form, please call Toll Free: 1-866-335-8319

Privacy Act Statement

(1) Collection of this information is authorized by the Federal Employees' Compensation Act (20 CFR 10.801), the Black Lung Benefits Act (20 CFR 725.704 and 725.705), the Energy Employees Occupational Illness Compensation Program Act of 2000 (20 CFR 30.701). (2) The information collected on this form will be used to ensure accurate medical provider information for payment of medical and vocational rehabilitation bills. (3) Disclosure of your Social Security Number and completion of this form is voluntary; however, failure to provide the information may result in bill payment delays. (4) This information may be furnished to data processing contractors, to the Department of Labor and to the IRS in accordance with law. (5) Furnishing all requested information will facilitate accurate and timely payment for services to the provider.

Public Burden Statement

We estimate that it will take an average of 8 minutes to complete this information collection, including time for reviewing the instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the information. If you have any comments regarding these estimates or any other aspect of this collection, including suggestions for reducing this burden, send them to the U.S. Department of Labor, Office of Workers' Compensation Programs, Room S-3524, 200 Constitution Avenue, N.W., Washington, D.C. 20210. **DO NOT SEND THE COMPLETED FORM TO THE ABOVE ADDRESS**

Provider Enrollment Form (Instructions)

A brief description of each data element is listed below. Be sure to sign and date the form when you submit it. For further information contact ACS or OWCP at the telephone numbers indicated on the form.

Block 1	Indicate whether this form is being used for a new enrollment, or to update an existing enrollment record. If the form is being submitted to update your record, enter your Provider Number or EIN.
Block 2	Indicate earliest date you treated any OWCP beneficiary.
Block 3	Type or print your practice name.
Block 4	Type or print your practice street address.
Block 5	Type or print your practice city.
Block 6	Type or print your practice state.
Block 7	Type or print your practice zip code (all nine digits).
Block 8	Type or print your practice telephone number.
Block 9	Type or print your practice FAX number (if applicable).
Block 10	Check your practice type-"a" for individual practice, "b" for a facility, or "c" for a group practice. Black Lung only: providers should disregard group practice information. If you checked "c" (group practice), fill out the appropriate parts of Block 10c on the reverse of the form for each professional that will be providing services under the group Provider Number (name, Social Security number, provider type code from list below, license number and State, expiration date of current license, specialty code or codes from the list below, and the date any certification expires). Continue on a separate sheet if necessary.
Block 11a	If you checked "a" or "b" (individual practice or facility) in Block 10, type or print your "Provider Type" code from the list below.
Block 11b	If you checked "a" or "b" (individual practice or facility) in Block 10, type or print the "Provider Type" that corresponds with the code you entered in Block 11a.
Block 11c	If you checked "a" or "b" (individual practice or facility) in Block 10 and selected "Other Provider" (code 96) or "Non-Medical Vendor (code 53), please explain why you are enrolling.
Block 12	If you checked "a" or "b" (individual practice or facility) in Block 10, type or print your Social Security number and/or your EIN, as appropriate.
Block 13	Blocks 13a thru 13c are required for hospitals only.
Block 13a	If you checked "b" (facility) in Block 10, type or print your Medicare number.
Block 13b	Type or print your National Provider Identifier (NPI). If you are a medical provider and you do not have an NPI, you can apply for one via the web at https://nppes.cms.hhs.gov. You can also apply via paper enrollment form CMS-101114. The completed form should be sent to: NPI Enumerator P.O. Box 6059 Fargo, ND 58108-6059
Block 13c	Type or print the taxonomy or taxonomies that correspond to the NPI you have entered. This is required for medical providers who have an NPI. You should use the taxonomy values that you submitted when applying for your NPI. More information on provider taxonomy is available at www.wpc-edi.com/taxonomy.

Block 14a	If you checked "a" (individual practice) in Block 10 and you are an M.D. or a D.O, type or print your name.
Block 14b	If you checked "a" (individual practice) in Block 10 and you are an M.D. or a D.O, type or print your license number and State. **Attach a copy of current M.D. or D.O. license.**
Block 14c	If you checked "a" (individual practice) in Block 10 and you are an M.D. or a D.O, type or print the expiration date of your current license. This license must be kept current to continue receiving payment.
Block 14d	If you checked "a" (individual practice) in Block 10 and you are an M.D. or a D.O, type or print your specialty code or codes from the list below.
Block 14e	If you checked "a" (individual practice) in Block 10 and you are an M.D. or a D.O, type or print the expiration date of any certification you currently hold.
Block 15	Type or print your UMWA Health & Retirement Funds Member Number, if any.
Block 16a	Type or print the address where you want your Remittance Advices and paper checks to be sent. If this address is identical to your billing address above in Blocks 4 through 7, indicate "same" and skip Blocks 16b, 16c and 16d.
Block 16b	Type or print your billing city if this is different from Block 5.
Block 16c	Type or print your billing State if this is different from Block 6.
Block 16d	Type or print your billing zip code (all nine digits) if this is different from Block 7.
Block 17	Indicate whether you have also completed a form for Electronic Funds Transfer (EFT).
Block 18	Indicate whether you are interested in billing electronically.

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Provider Type Codes (Blocks 10c, 11a and 11b)

01	General Hospital
02	Special Hospital/Outpatient Rehabilitation Facility
03	Psychiatric Hospital
05	Community Mental Health Center
19	End Stage Renal Hospital
20	Pharmacy
25	Physician (MD)
26	Physician (DO)
27	Podiatrist
28	Chiropractor
29	Physician Assistant
30	Advanced Registered Nurse Practitioner (ARNP)
31	CRNA
32	Psychologist
34	Licensed Midwife
35	Dentist
36	Registered Nurse (RN)
37	Licensed Practical Nurse (LPN)
38	Nursing Attendant
39	Massage Therapist

40	Ambulance
41	Contract Nurse
42	Air/Water Ambulance Company
43	Taxi
44	Public Transportation
45	Private Transportation
46	Hospice
50	Independent Laboratory
51	Portable X-Ray Company
52	Alternative Medicine
53	Non-Medical Vendor
54	Prosthetics/Orthotics
55	Vocational Rehabilitation (Training, Tuition and Schools)
56	Vocational Rehabilitation Counselor
57	Rehabilitation Maintenance
58	Assisted Re-employment
59	Relocation Expenses
60	Audiologist/Speech Pathologist
61	Second Opinion Contractor
62	Optometrist
63	Optician
65	Home Health Agency
66	Rural Health Clinic
68	Federally Qualified Health Center
69	Birthing Center
70	HMO or PHP
71	Physical Therapist
72	Occupational Therapist
73	Pulmonary Rehabilitation
74	Outpatient Renal Dialysis Facility
75	Medical Supplies/Durable Medical Equipment (DME)
76	Case Management Agency
77	Social Worker
78	Blood Bank
79	Alternative Payee
80	Pay-to-Intermediary
88	Ambulatory Surgery Center
89	Federal Facility (VA Hospital)
90	Skilled Nursing Facility (SNF)-Medicare Certified
91	Skilled Nursing Facility (SNF)-Non-Medicare Certified
92	Intermediate Care Facility (ICF)
93	Rural Hospital Swing Bed
94	Boarding House
95	Insurance Company (Third Party Carriers)
96	Other Provider
97	Billing Agent
98	Lien holder

* * * * * * *

Provider Specialty Codes (Blocks 10c and 14d)

01	Adolescent Medicine
02	Allergy
03	Anesthesiology
04	Cardiovascular Disease
05	Dermatology
06	Diabetes
07	Emergency Medicine
08	Endocrine Medicine
09	Family Practice
10	Gastroenterology
11	General Practice
12	Preventative Medicine
13	Geriatrics
14	Gynecology
15	Hematology
16	Immunology
17	Infectious Diseases
18	Internal Medicine
20	Neoplastic Diseases
21	Nephrology
22	Neurology
24	Neuropathology
25	Nutrition
26	Obstetrics
27	Obstetrics and Gynecology
28	Occupational Medicine
29	Oncology
30	Ophthalmology
31	Otolaryngology
32	Pathology
33	Pathology, clinical
34	Pathology, forensic
40	Pharmacology
41	Physical medicine and rehab
42	Psychiatry
44	Psychoanalysis
45	Public Health
46	Pulmonary diseases
47	Radiology
48	Diagnostic radiology
50	Therapeutic radiology
51	Rheumatology
52	Abdominal surgery
53	Cardiovascular surgery
54	Colon and rectal surgery
55	General surgery
56	Hand surgery
57	Neurological surgery
58	Orthopedic surgery
60	Plastic surgery
61	Thoracic surgery
62	Traumatic surgery
63	Urological surgery
64	Other physician specialty
65	Maternal fetal medicine
70	Adult, dentures only
71	General dentist
72	Oral surgeon, dentist
74	Other dentist
75	Adult primary care nurse practitioner
76	Clinical nurse specialist
77	College nurse practitioner
78	Diabetic nurse practitioner
80	Family/Emergency nurse
82	Geriatric nurse practitioner
84	Nurse anesthesiologist
85	Nurse midwife
86	OB/GYN nurse practitioner
88	Orthodontist
90	Occupational therapist
91	Physical therapist
92	Speech therapist
93	Respiratory therapist
95	Aged/disable waiver
96	Develop services waiver
97	Channeling waiver
98	Comm supp living arrangement
99	Other

Form **W-9**
(Rev. October 2007)
Department of the Treasury
Internal Revenue Service

Request for Taxpayer Identification Number and Certification

Give form to the requester. Do not send to the IRS.

Print or type
See Specific Instructions on page 2.

Name (as shown on your income tax return)

Business name, if different from above
PALM BEACH COUNTY BOARD OF COUNTY COMMISSIONERS (FIRE-RESCUE)

Check appropriate box: ☐ Individual/Sole proprietor ☐ Corporation ☐ Partnership
☐ Limited liability company. Enter the tax classification (D=disregarded entity, C=corporation, P=partnership) ▶ .....
☑ Other (see instructions) ▶ **GOVERNMENT**

☐ Exempt payee

Address (number, street, and apt. or suite no.)
301 NORTH OLIVE AVENUE

City, state, and ZIP code
WEST PALM BEACH, FLORIDA 33401

Requester's name and address (optional)
PAYMENT REMITTANCE ADDRESS:
PO BOX 3977
WEST PALM BEACH, FL 33401

List account number(s) here (optional)
PALM BEACH COUNTY FIRE-RESCUE

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on Line 1 to avoid backup withholding. For individuals, this is your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the Part I instructions on page 3. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN* on page 3.

Note. If the account is in more than one name, see the chart on page 4 for guidelines on whose number to enter.

Social security number
: :

or

Employer identification number
59 : 6000785

Part II Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me), and
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding, and
3. I am a U.S. citizen or other U.S. person (defined below).

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the Certification, but you must provide your correct TIN. See the instructions on page 4.

Sign Here **Signature of U.S. person** ▶ Lucrecia Tosca **Date** ▶ 6/11/09

General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

Purpose of Form

A person who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) to report, for example, income paid to you, real estate transactions, mortgage interest you paid, acquisition or abandonment of secured property, cancellation of debt, or contributions you made to an IRA.

Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN to the person requesting it (the requester) and, when applicable, to:

1. Certify that the TIN you are giving is correct (or you are waiting for a number to be issued),
2. Certify that you are not subject to backup withholding, or
3. Claim exemption from backup withholding if you are a U.S. exempt payee. If applicable, you are also certifying that as a U.S. person, your allocable share of any partnership income from a U.S. trade or business is not subject to the withholding tax on foreign partners' share of effectively connected income.

Note. If a requester gives you a form other than Form W-9 to request your TIN, you must use the requester's form if it is substantially similar to this Form W-9.

Definition of a U.S. person. For federal tax purposes, you are considered a U.S. person if you are:

- An individual who is a U.S. citizen or U.S. resident alien,
- A partnership, corporation, company, or association created or organized in the United States or under the laws of the United States,
- An estate (other than a foreign estate), or
- A domestic trust (as defined in Regulations section 301.7701-7).

Special rules for partnerships. Partnerships that conduct a trade or business in the United States are generally required to pay a withholding tax on any foreign partners' share of income from such business. Further, in certain cases where a Form W-9 has not been received, a partnership is required to presume that a partner is a foreign person, and pay the withholding tax. Therefore, if you are a U.S. person that is a partner in a partnership conducting a trade or business in the United States, provide Form W-9 to the partnership to establish your U.S. status and avoid withholding on your share of partnership income.

The person who gives Form W-9 to the partnership for purposes of establishing its U.S. status and avoiding withholding on its allocable share of net income from the partnership conducting a trade or business in the United States is in the following cases:

- The U.S. owner of a disregarded entity and not the entity,

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STATE OF FLORIDA 3056

DEPARTMENT OF HEALTH
BUREAU OF EMERGENCY MEDICAL SERVICES
ADVANCED LIFE SUPPORT LICENSE

This is to certify that PALM BEACH COUNTY FIRE-RESCUE
Name of Provider

405 PIKE ROAD, WEST PALM BEACH, FL 33411
Address

has complied with Chapter 401, Florida Statutes, and Chapter 64E-2, Florida Administrative Code, and is authorized to operate as an Advanced Life Support Service subject to any and all limitations specified in applicable Certificate(s) of Public Convenience and Necessity for the County(ies) listed below:

☒ TRANSPORT ☐ NON-TRANSPORT

PALM BEACH
County(ies)

John C. Burke
Chief, Bureau of Emergency Medical Services
Florida Department of Health

Date 11/03/2008 Expires 09/09/2010

This certificate shall be posted in the above mentioned establishment.

DH Form 1161, March 99