EMERGENCY MEDICAL SERVICES AGENCY
LOS ANGELES COUNTY

Los Angeles County Board of Supervisors

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June 12, 2013

TO: Each Chief Administrative Officer
Each Trauma Director and Trauma Physician
Non-County Trauma Hospitals

FROM: Cathy Chidester
Director

SUBJECT: **PHYSICIAN SERVICES FOR INDIGENTS PROGRAM FISCAL YEAR (FY) 2013-14--TRAUMA**

Cathy Chidester
Director

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Medical Director

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To improve health through leadership, service and education

The County of Los Angeles is opening enrollment in its Trauma Hospital Physician Services for Indigents Program (PSIP) for services provided to eligible patients. The County's Board of Supervisors has approved a three-year enrollment period which covers County FYs 2013-14 through 2015-16 (07-01-13 to 06-30-16). Please note the following changes in the attached documents:

Enrollment/Conditions of Participation

- These reimbursement procedures and policies apply to services rendered to eligible patients **for a period of three (3) years from July 1, 2013 through June 30, 2016.**

  The County has simplified the enrollment process. Providers need to submit only one Conditions of Participation Agreement and one Program Enrollment Provider Form for all County Programs.

  Each physician providing patient care under this program must complete an enrollment form. This form is for enrollment of a single physician, not a physician group. Any change in the physician information, e.g., office address change, will require resubmission of the enrollment form.

  The Conditions of Participation Agreement serves as the official "contract" between the private physician and the County. Each physician participating in PSIP must personally sign and return the agreement. This agreement need only be submitted once during the enrollment period, along with the enrollment form.

Reimbursement Rate

- The reimbursement rate for services remains at 50% of the approved County fee schedule, as defined in Section II A of the attached Physician Reimbursement Policies, not to exceed 100% of charges.

The following PSIP enrollment documents are attached to this letter:

1. **PROGRAM ENROLLMENT PROVIDER FORM - JULY 1, 2013 TO JUNE 30, 2016**
2. **CONDITIONS OF PARTICIPATION AGREEMENT - JULY 1, 2013 TO JUNE 30, 2016**
3. **BILLING PROCEDURES**
4. **PHYSICIAN REIMBURSEMENT POLICIES**
5. **INSTRUCTIONS FOR CLAIMS SUBMISSION AND DATA COLLECTION**
6. **DEMOGRAPHIC DATA FORM**

KEY INFORMATIONAL POINTS IN THE ABOVE-REFERENCED DOCUMENTS:

-- These reimbursement procedures and policies apply for services rendered to eligible patients **for a period of three (3) years from July 1, 2013 through June 30, 2016.**

-- An eligible "trauma" patient is one at a designated trauma hospital requiring a **TRAUMA PATIENT SUMMARY (TPS)** number. Claims received without a TPS will be reimbursed at 9% of the approved fee schedule under the PSIP Program. Claims with an inaccurate or invalid TPS will be rejected until accurate information is submitted.

PLEASE NOTE: We cannot reimburse physicians if TEMIS indicates the patient has third-party coverage. Such claims are being returned to the physician until the TEMIS database is updated.

-- Physicians providing service to eligible trauma patients may be reimbursed for services provided during the entire acute hospitalization.

-- These procedures apply to all physicians providing care to eligible trauma patients, INCLUDING EMERGENCY DEPARTMENT PHYSICIANS.

-- Each physician must complete a Program Enrollment Provider Form and Conditions of Participation Agreement before their claims will be processed. These documents may accompany the first claims.

-- Enrollment forms and all claims from physicians at trauma hospitals should be mailed directly to the County's Contracted Claims Adjudicator:

American Insurance Administrators (AIA)
P.O. BOX 2340
Bassett, CA 91746-0340
(800) 303-5242

Thank you for your continued participation in the County's Trauma Hospital System.

CC:AM

Enclosures

c: Los Angeles County Medical Association
Hospital Association of Southern California (HASC)

COUNTY OF LOS ANGELES • DEPARTMENT OF HEALTH SERVICES

PHYSICIAN REIMBURSEMENT PROGRAM

PROGRAM ENROLLMENT PROVIDER FORM
JULY 1, 2013 TO JUNE 30, 2016

Completion of Enrollment Form is required by each physician

Physician Name: _____
(Last Name) (First Name) (M.I.)

Address: _____ City: _____ Zip Code: _____

Telephone No.: (____)_____ Contact Person: _____

E-mail Address: _____

Primary Specialty: _____ State License Number: _____

U.P.I.N.: _____ Payee Tax I.D.#: _____

Payee Address: _____ City: _____ State: _____ Zip Code _____

Physician/Group name must match IRS Tax ID Number

IF PAYEE IS A PHYSICIAN GROUP, COMPLETE GROUP INFORMATION BELOW:

Group Name: _____

IF USING A BILLING COMPANY, COMPLETE BILLING COMPANY INFORMATION BELOW:

Company Name: _____ E Mail Address: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Telephone Number: ( ) _____ Contact Person: _____

LIST ALL HOSPITAL WHERE MEDICAL SERVICES ARE PROVIDED WITHIN LOS ANGELES COUNTY

Hospital Name: _____ Address: _____

Hospital Name: _____ Address: _____

Hospital Name: _____ Address: _____

Hospital Name: _____ Address: _____

Hospital Name: _____ Address: _____

Hospital Name: _____ Address: _____

If information on this form changes in any way, a new provider application must be submitted with the corrected information. This application must be completed by each physician providing services claimed under this program.

As a condition of claiming reimbursement under the Physician Services for Indigents program and/or the Trauma Physician Services Program, I certify that the above information is true, and complete to the best of my knowledge.

_____ _____
SIGNATURE OF PHYSICIAN DATE

IMPORTANT: For prompt processing, return this form as soon as possible to:

AMERICAN INSURANCE ADMINISTRATORS
P.O. BOX 2340
Bassett, CA 91746-0340

COUNTY OF LOS ANGELES • DEPARTMENT OF HEALTH SERVICES

NON-COUNTY PHYSICIANS INDIGENT SERVICES PROGRAMS

JULY 1, 2013 TO JUNE 30, 2016
CONDITIONS OF PARTICIPATION AGREEMENT

SUBMIT TO: AMERICAN INSURANCE ADMINISTRATORS (AIA)
P.O. BOX 2340
BASSETT, CALIFORNIA 91746-0340

The undersigned physician (hereinafter "Physician") certifies that claims submitted hereunder are for services provided by him/her to patients who do not have health insurance coverage for medical services and care, and 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 federal government. Programs covered by this single agreement include:

Physician Services for Indigents Program -- Emergency services (at hospitals defined in the Billing Procedures) for up to 72 hours (except for eligible trauma patients under other programs below).
Trauma Services for Indigents Program -- Trauma services provided in an acute setting for full length of stay at a Los Angeles County designated trauma center.
Impacted Hospital Program -- Emergency services and/or inpatient services provided for up to six inpatient days at a Los Angeles County designated Impacted Hospitals (associated with closure of MLK-Harbor Hospital).
Physicians Services for Indigents Program-MetroCare -- Inpatient services for patients transferred from a County-operated or Impacted Hospitals (see above) to St. Vincent Medical Center.

Physician acknowledges receipt of a copy of the applicable Billing Procedures for each program (hereinafter "Billing Procedures"), promulgated by the County of Los Angeles, Department of Health Services, the terms and conditions of which are incorporated herein by reference.

Physician agrees that all obligations and conditions stated in the Billing Procedures will be observed by him/her, including, but not limited to, the proper refunding of monies to the County when patient or third-party payments are made after reimbursement under this claiming process has been received; the cessation of current, and waiver of future, collection efforts upon receipt of payment; and the preparation, maintenance, and retention of service and finance records, including their availability for audit. Physician affirms that for all claims submitted, reasonable efforts to identify third-party payers have been made, no third-party payers have been discovered, and no payment has been received.

Physician agrees to assign and subrogate all rights that s/he may have against any patient, his/her responsible relative, any third party tortfeasor or any other party for reimbursement as a result of care and services provided by Physician, and/or his/her staff, for which a claim has been submitted to County under any of these programs. At its sole discretion, County, and/or its contractor, may proceed independently against such parties for reimbursement to the extent permitted by law. The rights hereby assigned and subrogated to County under this provision include reimbursement for the full amount of any customary or actually billed charges of Physician, and his/her staff, for patient care and services regardless of the amount the Physician has received under any of these programs. Physician agrees to cooperate with County and/or its contractors in the exercise of the rights assigned and subrogated to County under this provision.

Physician expressly acknowledges and accepts that any County liability for claims submitted hereunder is at all times subject to conditions defined in the Billing Procedures, including, but not limited to, (1) availability of monies, (2) priority of claim receipt, and (3) audit and adjustments. In accordance with instructions in the Billing Procedures, Physician agrees to submit required documents for claims, and provide other patient data as may be required by the County.

Physician certifies that information on claims submitted by him/her is true, accurate, and complete to the best of his/her knowledge.

TYPED/PRINTED NAME OF PHYSICIAN	TAX ID NUMBER
PRIMARY SPECIALTY OF PHYSICIAN	SIGNATURE OF PHYSICIAN
STATE LICENSE NUMBER	DATE

COUNTY OF LOS ANGELES ● DEPARTMENT OF HEALTH SERVICES

TRAUMA PHYSICIAN SERVICES PROGRAM

BILLING PROCEDURES

JULY 1, 2013 TO JUNE 30, 2016

I. INTRODUCTION

Pursuant to provisions of the State of California Welfare and Institutions Code, Sections 16950 et seq., and Health and Safety Code ("HSC"), Sections 1797.98a, et seq., a Physician Services Account has been established by the County of Los Angeles ("County") to pay for contracts with private physicians ("Physician") to provide reimbursement for certain professional services they have rendered to eligible indigent patients. County has determined that a portion of the Physician Services Account should be allocated to a special County sub-account which will serve as a source of reimbursement for otherwise uncompensated physician services rendered to trauma patients in hospitals designated by County contract as trauma hospitals.

This document defines the procedures which must be followed by a Physician in seeking reimbursement from this trauma services sub-account. Reimbursement is also limited to the policy parameters set forth herein and incorporated in the attached "Department of Health Services' Physician Reimbursement Policies." The County may revise such policies from time to time as deemed necessary or appropriate and if approved by the Board of Supervisors.

Submission of a claim for trauma services by a Physician under these procedures establishes (1) a contractual relationship between the County and the Physician covering the services provided and (2) signifies the Physician's acceptance of all terms and conditions herein.

This claiming process is effective immediately; is only valid for trauma services to the extent that monies are available therefor; and are subject to revisions as required by State laws and regulations and County requirements.

In no event may this claiming process be used by a Physician if his/her services are included as part of the trauma hospital services claimed for reimbursement by the hospital under County's contract with the hospital.

This claiming process may not be used by a Physician for services for which a billing has previously been submitted or could be submitted to the County under any other County contract or claiming process.

This claiming process may not be used by a physician if he or she is an employee of a County trauma hospital.

II. PHYSICIAN ELIGIBILITY

A. The Physician must complete a Trauma Physician Services Program "Conditions of Participation Agreement" and "Program Enrollment Provider Form" and provide them to the County's Office of Emergency Medical Services ("EMS") Agency in care of the contracted Claims Adjudicator (see address on page 4). Physician claims will not be accepted if said Agreement and form are not on file with the EMS Agency.

B. Any Physician, **including an emergency department Physician,** who responds as part of an organized system of trauma care to eligible patients in a hospital designated by formal County contract as a "trauma hospital" may submit a claim hereunder. (Physician employees of a County trauma hospital are not, however, eligible for reimbursement under this claiming process.)

C. Physicians and surgeons shall be eligible to receive payment for patient care services provided by, or in conjunction with, a properly credentialed nurse practitioner or physician's assistant for care rendered under the direct supervision of a physician and surgeon who is present in the facility where the patient is being treated and who is available for immediate consultation. Payment shall be limited to those claims that are substantiated by a medical record and that have been reviewed and countersigned by the supervising physician and surgeon in accordance with regulations established for the supervision of nurse practitioners and physician assistants in California.

III. PATIENT ELIGIBILITY/BILLING EFFORTS

Patients covered by this claiming process are only those for whom the trauma hospital is required to complete a trauma patient summary ("TPS") form, and who do not have health insurance coverage for emergency services and care, and 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 federal government, including Medi-Cal, but with the exception of claims submitted for reimbursement through Section 1011 of the Federal Medicare Prescription Drug, Improvement and Modernization Act of 2003.

During the time prior to submission of the bill to the County, the Physician must have made reasonable efforts to obtain reimbursement and not received payment for any portion of the amount billed. For purposes of this claim process, reimbursement for unpaid Physician billings shall be limited to the following:

(a) patients for whom a Physician has conducted reasonable inquiry to determine if there is a responsible private or public third-party source of payment; and

(b) patients for whom a Physician has billed all possible payment sources, but has not received reimbursement for any portion of the amount billed and physician has attempted to settle by offering to bill patients a reduced amount, i.e., a percentage of total charges; and

(c) either of the following has occurred:

1. A period of not less than three (3) months has passed from the date the Physician billed the patient or responsible third party, during which time the Physician has made two attempts to obtain reimbursement and has not received payment for any portion of the amount billed.

2. The Physician has received actual notification from the patient or responsible third party that no payment will be made for the services rendered.

Upon receipt of payment from the County under this claiming process, Physician must cease any current, and waive any future, collection efforts to obtain reimbursement from the patient or responsible third party. During the period after a claim has been submitted and prior to receipt of payment, the Physician can continue attempts to collect from a patient. However, once the Physician receives payment from the County, further collection efforts shall cease.

Examples of when these County collection efforts might occur would include, but not necessarily be limited to, situations where there are third-party tortfeasors responsible for a patient's medical expenses. If, after receiving payment from the County hereunder, Physician is reimbursed by a patient or a responsible third party, Physician shall immediately notify the County (see address below) in writing of the payment, and reimburse the County the amount received from the County.

MAKE REFUND CHECK PAYABLE TO:
County of Los Angeles/Department of Health Services

Refund checks should be accompanied by:
-- a copy of the Remittance Advice, and
-- a specific explanation for the refund, e.g., received payment for services from Medi-Cal, etc.

SUBMIT NOTIFICATION AND/OR REFUND TO:
County of Los Angeles/Department of Health Services
Special Funds Unit
313 North Figueroa Street, Room 505
Los Angeles, CA 90012
ATTN: **PHYSICIAN INDIGENT PROGRAM**

IV. CONDITIONS OF REIMBURSEMENT

Payment is contingent upon adherence to State law and County requirements regarding eligible claims, and provision of data as specified in these Billing Procedures.

V. CLAIM PERIOD

Claims may only be submitted for eligible services provided. All claims for services provided during a fiscal year (July 1 through June 30) must be received by County's Claim Adjudicator no later than October 31st of the following fiscal year. Claims received after this deadline has passed will not be paid.

VI. REIMBURSEMENT

Reimbursement of a valid claim hereunder will be limited to a maximum of 50% of the Official County Fee Schedule (OCFS), not to exceed 100% of Physician charges. The OCFS, which establishes rates of reimbursement deemed appropriate by the County, utilizes the most current Physicians' Current Procedural Terminology (CPT-4) codes in conjunction with the Resource Based Relative Value Scale (RBRVS) unit values and a County determined weighted average conversion factor. The conversion factor for all medical procedures other than anesthesiology is $79.49 per relative unit value. The conversion factor for anesthesiology procedures is $48.77 per relative unit value.

VII. COMPLETION OF FORMS

A. Complete "Conditions of Participation Agreement" for Trauma Physician Services Program (sample attached). Submit one original signed Agreement to the contracted Claims Adjudicator:

American Insurance Administrators (AIA)
P.O. BOX 2340
Bassett, CA 91746-0340

B. Complete one HFCA-1500 Form per patient.

C. Complete one Physician Services for Indigents Program (PSIP) Demographic Data Form per patient (sample attached). Physicians are required to provide patient data for services provided in a hospital to the extent the information is available from the hospital. Additional requirements for data submission have been established. Refer to the attached Instructions for Submission of Claims and Data Collection.

VIII. ELECTRONIC BILLING

As an option, the County's Claims Adjudicator can receive claims electronically. The record layout necessary for electronic submission shall be obtained directly from the County Claims Adjudicator at (800) 303-5242 Ext. 518.

IX. SUBMIT CLAIM(S) TO COUNTY'S CONTRACTED CLAIMS ADJUDICATOR

American Insurance Administrators (AIA)
P.O. BOX 2340
Bassett, CA 91746-0340
ATTN: TRAUMA CLAIMS

X. CLAIM REJECTION AND APPEALS

A. Revised claims previously rejected for incomplete information must be received by the contracted Claims Adjudicator within 20 calendar days from the date of the rejection letter; however, in no case shall claims be resubmitted later than the last working day of June of the following fiscal year.

B. The Physician must submit an appeal of any denied claim within forty-five (45) calendar days from the date of the denied Remittance Advice. A denied claim can be appealed once; however, after the appeal is dispositioned, a further appeal will not be considered. All resubmissions or appeals must be received by Claims Adjudicator within twelve (12) months after the close of the fiscal year during which services were provided, no later than the last working day of June of the following fiscal year. All appeals shall be prepared and sent in accordance with the directions set forth in Exhibit "A".

XI. INFORMATION CONTACTS

For Status of Claims, call:
AIA Physician Hotline - (800) 303-5242

XII. COUNTY LIABILITY/PAYMENT/SUBROGATION

Payment of any claim under this claiming process is expressly contingent upon the availability of monies allocated therefor by the State and by the County of Los Angeles Board of Supervisors. To the extent such monies are available for expenditure, valid claims may be paid. Valid claims will be paid in the order of receipt; that is, if a complete and correct claim is received by County, it will have priority over claims subsequently received.

Physician agrees to assign and subrogate all rights that s/he may have against any patient, his/her responsible relative, any third party tortfeasor or any other party for reimbursement as a result of care and services provided by Physician, and/or his/her staff, for which a claim has been submitted to County under the PSIP. At its sole discretion, County, and/or its contractor, may proceed independently against such parties for reimbursement to the extent permitted by law. The rights hereby assigned

and subrogated to County under this provision include reimbursement for the full amount of any customary or actually billed charges of Physician, and his/her staff, for patient care and services regardless of the amount the Physician has received under the Trauma Services for Indigents Program. Physician agrees to cooperate with County and/or its contractors in the exercise of the rights assigned and subrogated to County under this provision.

XIII. GENERAL OBLIGATION OF PHYSICIANS SUBMITTING CLAIMS

In addition to any Physician duties specified previously herein, Physicians using this claiming process are obligated as follows:

A. Records/Audit Adjustment

1. Physician shall immediately prepare, and thereafter maintain, complete and accurate records sufficient to fully and accurately reflect the services provided, the costs thereof, all collection attempts from the patient and third-party payers, and revenue collected, if any, for which claim has been made under this claiming process.

2. All such records shall be retained by Physician at a location in Los Angeles County for a minimum of three (3) years following the last date of the Physician services to the patient.

3. Such records shall be made available during normal County working hours to representatives of the County and/or State, upon request, at all reasonable times during such three year period for the purposes of inspection, audit, and copying. Photocopying capability must be made available to County representatives during an on-site audit.

4. County may periodically conduct an audit of the Physician's records. Audits shall be performed in accordance with generally accepted auditing standards. The audit may be conducted on a single claim, a group of claims, or a statistically random sample of claims from the adjudicated universe for a fiscal year. The scope of the audit shall include an examination of patient medical and financial records, patient/insurance billing records, and collections agency reports associated with the sampled claims.

Audited claims that do not comply with program requirements shall result in a refund to the County of the claim amount plus an assessment of fifty percent (50%) of the amount paid for each claim. Audit results may be appealed to the EMS Agency Director, or his/her designee

If an audit of Physician or hospital records conducted by County and/or State representatives relating to the services for which claim was made and paid

hereunder finds that (1) the records are incomplete or do not support the medical necessity for all or a portion of the services provided, or (2) no records exist to evidence the provision of all or a portion of the claimed services, or (3) Physician failed either to report or remit payments received from patients or third parties as required herein, or (4) the patient was ineligible for services hereunder, or (5) Physician did not otherwise qualify for reimbursement hereunder, Physician shall reimburse the County as stated above.

County also reserves the right to exclude Physician from reimbursement of future claims for any failure to satisfy conditions of this claiming process.

B. Indemnification/Insurance

By utilizing this claiming process, the Physician certifies that the services rendered by him/her, and for which claim is made, are covered under a program of professional liability insurance with a combined single-limit of not less than one million dollars ($1,000,000) per occurrence and three million dollars ($3,000,000) aggregate.

By utilizing this claiming process, the Physician further certifies that his/her workers' compensation coverage is in an amount and form to meet all applicable requirements of the California Labor Code, and that it specifically covers all persons providing services on behalf of the Physician and all risks to such persons.

C. Non-discrimination

In utilizing this claiming process, the Physician signifies that he/she has not discriminated in the provision of services for which claim is made because of race, color, religion, national origin, ancestry, sex, age, physical or mental disability, or medical condition and has complied in this respect with all applicable non-discrimination requirements of Federal and State law.

XIV. COMPLIANCE WITH HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996

Under this Agreement, Contractor ("Business Associate") provides services ("Services") to County ("Covered Entity") and Business Associate receives, has access to or creates Protected Health Information in order to provide those Services.

Covered Entity is subject to the Administrative Simplification requirements of the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191 ("HIPAA"), and regulations promulgated thereunder, including the Standards for Privacy of Individually Identifiable Health Information ("Privacy Regulations") and the Health Insurance Reform: Security Standards ("the Security Regulations") at 45 Code

of Federal Regulations (C.F.R.) Parts 160 and 164 (together, the "Privacy and Security Regulations"). The Privacy and Security Regulations require Covered Entity to enter into a contract with Business Associate ("Business Associate Agreement") in order to mandate certain protections for the privacy and security of Protected Health Information, and those Regulations prohibit the disclosure to or use of Protected Health Information by Business Associate if such a contract is not in place.

Further, pursuant to the Health Information Technology for Economic and Clinical Health Act, Public Law 111-005, *title XIII and title IV of Division B* , ("HITECH Act"), effective February 17, 2010, certain provisions of the HIPAA Privacy and Security Regulations apply to Business Associates in the same manner as they apply to Covered Entity and such provisions must be incorporated into the Business Associate Agreement.

This Business Associate Agreement and the following provisions are intended to protect the privacy and provide for the security of Protected Health Information disclosed to or used by Business Associate in compliance with HIPAA's Privacy and Security Regulations and the HITECH Act, as they now exist or may hereafter be amended.

COUNTY OF LOS ANGELES ! DEPARTMENT OF HEALTH SERVICES

PHYSICIAN REIMBURSEMENT PROGRAMS

PHYSICIAN REIMBURSEMENT POLICIES

JULY 1, 2013 TO JUNE 30, 2016

I. POLICY STATEMENT

THE PURPOSE OF THIS POLICY IS TO ENSURE THE COUNTY'S CONFORMANCE WITH STATUTORY AND REGULATORY REQUIREMENTS, AND TO ADDRESS PRIORITIES OF THE HEALTH CARE SYSTEM WHICH ARE CRITICAL TO PROVIDING FOR THE MEDICAL NEEDS OF THE INDIGENT POPULATION, WITHIN THE LEVEL OF AVAILABLE FUNDS.

II. GENERAL RULES

A. Official County Fee Schedule: The Official County Fee Schedule is used to determine reimbursement rates for eligible physician claims. The Official County Fee Schedule, which establishes rates of reimbursement deemed appropriate by the County utilizes the most current Physicians' Current Procedural Terminology ("CPT-4") codes which coincides with the current Resource Based Relative Values Scale ("RBRVS") unit values and a County-determined weighted average conversion factor. The conversion factor for all medical procedures except anesthesiology is $79.49 per relative unit value. The conversion factor for anesthesiology procedures is $48.77 per relative unit value. Reimbursement is also limited to the policy parameters contained herein.

B. Eligible Period: Reimbursement shall be for emergency medical services provided on the calendar day on which emergency services are first provided and on the immediately following two calendar days. EXCEPTION: Trauma physicians providing trauma services at County contract trauma hospitals may bill for trauma physician services provided beyond this period.

C. Nonemergent Pediatric and OB Services: Reimbursement may be provided for nonemergency, medically necessary services **ONLY IF** they are provided to a patient who is under 21 years of age (a pediatric patient) or to a pregnant woman from time of conception until ninety (90) calendar days following the end of the month in which the pregnancy ends (an obstetric patient).

D. Medi-Cal/Medicare Exclusions:

1. Procedures which are not covered in the Medi-Cal Program's Schedule of Maximum Allowances ("SMA") are excluded from reimbursement.

2. Procedures which are covered in Medi-Cal's SMA but require a Treatment Authorization Request ("TAR") are excluded from reimbursement; however, will be considered upon appeal and/or provision of applicable operative and/or pathology reports.

E. Screening Exams: Payment will be made for emergency department medical screening examinations required by law to determine whether an emergency condition exists.

F. Assistant Surgeons: Reimbursement for assistant surgeons will be at a rate of 16% of the primary surgeon's fee.

G. Pediatric Hospitalization Over Five Days: All claims for pediatric patients hospitalized in excess of five calendar days must be accompanied by a statement from the hospital indicating sources the hospital utilized for reimbursement.

H. Multiple Surgery Procedure Codes: Adjudication of claims involving multiple surgery procedure codes performed in an inpatient operating room requires submission of operative reports. No more than five (5) Procedure Codes shall be paid as follows: 100% for 1st Procedure and 50% for the 2nd through 5th Procedures.

I. Nurse Practitioner and Physician's Assistant Services: Physicians and surgeons shall be eligible to receive payment for patient care services provided by, or in conjunction with, a properly credentialed nurse practitioner or physician's assistant for care rendered under the direct supervision of a physician and surgeon who is present in the facility where the patient is being treated and who is available for immediate consultation. Payment shall be limited to those claims that are substantiated by a medical record and that have been reviewed and countersigned by the supervising physician and surgeon in accordance with regulations established for the supervision of nurse practitioners and physician's assistants in California.

III. INELIGIBLE CLAIMS

A. Office Visits: Procedures performed in a physician's office will be denied unless documentation is provided to show that an eligible service was provided to either a pediatric or an obstetric patient. If a claim is made for services provided to an obstetric patient, the expected date of delivery ("EDD") must be included on the Physician Services for Indigents Program (PSIP) Demographic Data Form.

(Item #20). An obstetric claim submitted without the EDD will be rejected.

B. Duplicate Procedures: Claims which include duplicate procedures provided to the same patient for the same episode of care are generally excluded from reimbursement. This does not apply for Evaluation & Management codes billed by separate physicians.

C. Unlisted Procedures: Procedures which are not listed in the Official County Fee Schedule are excluded from reimbursement.

D. Non-physician Procedures: Procedures commonly not performed by a physician will be denied (e.g., venipuncture). Claims will be reviewed and considered on appeal only.

E. Insurance Rejections: Claims for patients with potential insurance or other third-party payer coverage will be denied unless a notice of rejection from the insurance company or other third-party payer is provided to the County. The rejection notice should indicate either (1) the patient is not a covered beneficiary or (2) the term of coverage expired prior to the date of the claimed service. If insurance or other third-party coverage has been denied for other reasons, e.g., the deductible has not been met, the type or scope of service has been classified as a nonemergency, or other similar issues denying insurance coverage, the claim will be denied. Where limited insurance policies have been exhausted by hospital billings, physician claims will be reviewed and considered on appeal.

IV. EXCLUSIONS

A. Radiology/Nuclear Medicine (Codes 70002 - 79499): Reimbursement for radiology codes will be limited to readings performed while the patient is in the emergency department or other eligible site. Additionally, payment will only be made for the first radiology claim received by the County per patient per episode of care. Subsequent radiology claims for the same patient/episode will be denied.

B. EKG (Code 93010): Reimbursement for EKG codes will only be made for the first EKG claim received by the County per patient per episode of care. Subsequent EKG claims for the same patient/episode will be denied.

C. Pathology (Codes 80104 - 89999): Reimbursement for pathology codes will be limited to codes 86077, 86078, and 86079. Additionally, codes 88329, 88331, and 88332 will be reimbursed only if the pathologist is on site and pathology services are requested by the surgeon.

D. Surgery (Codes 10000 - 69979): There are no exclusions as long as the procedure is covered in Medi-Cal's SMA and does not require a TAR (see Medi-Cal Exclusions in section A. above).

E. Anesthesia: There are no exclusions as long as the procedure is covered in Medi-Cal's SMA and does not require a TAR (see Medi-Cal Exclusions in section A. above).

F. Modifiers: Reimbursement is excluded for all modifiers except radiology.

G. Prior Dx Codes: Reimbursement will no longer be made for wound checks and suture removal.

H. Critical Care (Codes 99291 and 99292): Reimbursement will not be made on critical care codes after the first 24 hours of service.

I. Newborn Care (Inpatient Code 99431 and Emergency Department Code 99283): Reimbursement will only be made once for the same recipient by any provider and only if accompanied by a Medi-Cal denial. V30 through V30.2 codes are reimbursable only if a copy of Medi-Cal denial is provided.

V. ADDITIONAL EXCLUSIONS

Upon approval of the Board of Supervisors, the County may revise the Physician Reimbursement Polices from time to time as necessary or appropriate.

VI. APPEALS

Appeals for claims rejected or denied may be submitted to the Physician Reimbursement Advisory Committee ("PRAC"), a committee of physicians selected by Hospital Council of Southern California and by the Los Angeles County Medical Association. Appeals shall include the Physician Services for Indigents Program (PSIP) Demographic Data Form, HCFA-1500, operative reports, if applicable, and supporting documents as needed. Appeals shall be mailed to the contracted Claims Adjudicator:

American Insurance Administrators (AIA)
P.O. BOX 2340
Bassett, CA 91746-0340
ATTN: APPEALS UNIT

COUNTY OF LOS ANGELES ! DEPARTMENT OF HEALTH SERVICES

NON-COUNTY PHYSICIANS

INSTRUCTIONS FOR SUBMISSION OF CLAIMS AND DATA COLLECTION

JULY 1, 2013 TO JUNE 30, 2016

GENERAL INFORMATION

Physicians must submit both a **CMS-1500 Form** and a **Physician Services for Indigents Program (PSIP) Demographic Data Form** for each patient's care if they are claiming reimbursement under the County's private physician PSIP. Information from both the PSIP Demographic Data Form and the CMS-1500 Form are used by the County to comply with State reporting mandates. **An original PSIP Demographic Data Form must be completed for each patient. Xeroxed documents/information will be rejected.**

PATIENT INFORMATION: Physicians are required to make reasonable efforts to collect all data elements; however, physicians are only required to provide patient data for services provided in a hospital to the extent the information is available from the hospital. If, after reasonable efforts are made, some data elements cannot be obtained, indicate "N/A" (not available) in the space for the data element which was not obtainable. **Claims for services provided to patients as INPATIENT or OUTPATIENT/OFFICE VISIT shall not be accepted without completion of all data elements unless a reasonable justification is provided.**

ALL CLAIMS should be submitted to American Insurance Administrators.

TRAUMA PHYSICIANS - SUBMIT CLAIMS:

American Insurance Administrators (AIA)
P.O. BOX 2340
Bassett, CA 91746-0340
Attention: **TRAUMA CLAIMS**

ALL OTHER PHYSICIANS--SUBMIT CLAIMS TO:

American Insurance Administrators (AIA)
P.O. BOX 2340
Bassett, CA 91746-0340
Attention: **PHYSICIAN INDIGENT PROGRAM CLAIMS**

Contact: AIA Physician Hotline - (800) 303-5242 Ext. 518

COMPLETION OF PSIP DEMOGRAPHIC DATA FORM

PATIENT INFORMATION (Items #1-10)

1. TPS #

Enter Trauma Patient Summary number if claim is for a contract trauma patient. If claim is for a non-trauma patient, leave box blank.

2. SOCIAL SECURITY #

Enter Patient's social security number. Failure to provide the social security number must be justified in item # 26 (REASON) of the PSIP Demographic Data Form.

3. PATIENT'S NAME

Enter Patient's last name, first name, and middle initial. (1) If Patient is a minor, parent/guardian name must be provided.

4. PLACE OF BIRTH

Enter Patient's city, state, and country of birth.

5. MOTHER'S MAIDEN NAME

Enter Patient's mother's maiden name.

6. ETHNICITY

Check appropriate box to indicate Patient's racial/ethnic background:

(1) white
(2) black
(3) asian/pacific islander
(4) native american/eskimo/aleut
(5) hispanic
(6) filipino
(7) other (or none of the above)

7. EMPLOYMENT TYPE

Check appropriate box to indicate occupation of Patient or Patient's family's primary wage earner:

(0) unemployed
(1) farming/forestry/fishing
(2) laborers/helpers/craft/inspection/repair/production/transportation
(3) sales/service
(4) executive/administrative/managerial/professional/technical/related support
(5) other

*** **Note:** **Employment type must be consistent with required employment information provided on the CMS-1500. Claims with inconsistent information will be rejected.**

8. MONTHLY INCOME

Enter total of Patient's or Patient's family's primary wage earner's wages and salaries (including commissions, tips, and cash bonuses), net income from business or farm, pensions, dividends, interest, rents, welfare, unemployment or workers' compensation, alimony, child support, and any money received from friends or relatives during the previous month by all related family members currently residing in the patient's household.

9. FAMILY SIZE

Enter the number of individuals related by birth, marriage, or adoption who usually share the same place of residence (including any active duty members of the military who are temporarily away from home). This number includes a head of household who is responsible for payment, and all of this person's dependents. The following family members should be included in the family size:

- parent(s)
- children under 21 years of age living in the home. A child under 21 years of age who is in the military would be counted only if he/she gave his/her entire salary to the parent(s) for support of the family.
- children under 21 years of age living out of the home but supported by the parent(s), e.g., a child in college

*** **Note: For a minor child, entering one (1) in family size will result in rejection.**

10. SOURCE OF INCOME

Check appropriate box to indicate the primary source (largest single source) of family income:

(0) none
(1) general relief
(2) wages
(3) self-employed
(4) disability
(5) retirement
(6) other, e.g., unemployment/VA benefits/interest/dividends/rent/child support/alimony, etc.

PATIENT INFORMATION VERIFICATION (Items #26-27)

26. REASON(S)

If Patient Information is not available for services provided to patients as INPATIENT or OUTPATIENT/OFFICE VISIT, submitting physician/agency is required to enter a reason(s) why information was not obtained and N/A was indicated. All reasonable efforts must be taken to obtain patient information from the hospital.

*** **Note: N/A will only be accepted for patients seen through the emergency department. Patients admitted to the hospital (INPATIENT) and seen as a doctor's appointment (OUTPATIENT/OFFICE VISIT) shall not be accepted without completion of all data elements unless a reasonable justification is provided.**

27. SIGNATURE

If Patient Information is not available for services provided to patients as INPATIENT or OUTPATIENT/OFFICE VISIT, enter a signature of the physician/submitting agency attesting to the fact that every attempt to obtain information was made. If all data elements are complete, a signature is not required.

PHYSICIAN SERVICES (Items #20-25)

20. PHYSICIAN FUND

Check appropriate box to indicate type of claim being submitted:

(1) **CONTRACT TRAUMA** - trauma care provided at the following hospitals:

Antelope Valley Hospital
California Hospital Medical Center
Cedars-Sinai Medical Center
Childrens Hospital Los Angeles
Henry Mayo Newhall Memorial Hospital
Holy Cross Medical Center
Huntington Memorial Hospital
Memorial Hospital Medical Center of Long Beach
Northridge Hospital Medical Center
St. Francis Medical Center
St. Mary Medical Center
UCLA Medical Center
Other hospitals as approved by the Board of Supervisors and designated by the EMS Agency

(2) **NON-CONTRACT EMERGENCY** - all emergency services provided by a licensed Physician excluding specialty care provided by a designated contract trauma hospital as per (1) above.

(3) **PEDIATRICS** - pediatric services means all medical services rendered by any licensed Physician to persons from birth to 21 years of age, and shall include attendance at labor and delivery.

(4) **OBSTETRICS** - obstetric services means the diagnosis of pregnancy and all other medical services provided by a licensed Physician to a pregnant woman during her pregnancy from the time of conception until 90 days following the end of the month in which the pregnancy ends.

***** Note: If "Obstetrics" is checked, the Expected Date of Delivery (EDD) must be entered.**

21. SERVICE SETTING
Check one of the following:

(1) inpatient
(2) emergency department
(3) outpatient/office visit, CHECK ONE OF: (a) primary care (b) specialty care

***** Note: If (1) INPATIENT or (2) OUTPATIENT/OFFICE VISIT is checked, items #2-10 cannot indicate "N/A" (not available) unless a reasonable justification is indicated in item #26 (REASON).**

22. PHYSICIAN'S NAME AND STATE LICENSE NUMBER

Enter Physician's name and State license number.

23. PAYEE NAME, ADDRESS AND TAX ID NUMBER

Enter payee name, address, and nine (9) digit federal tax ID number.

24. DATE BILLED COUNTY

Enter date Physician billed the County.

CHARGES

Enter total amount of Physician charges.

25. CONTACT PERSON/TELEPHONE NO.

Enter name and telephone number of individual authorized to answer questions regarding the claim.

COMPLETION OF CMS-1500 FORM

The following CMS-1500 items must be completed:

Patient's Name (last, first, middle initial)

Patient's Date of Birth and Sex

Patient's Address (city, state, zip)

Employment Information

*** **Note:** **All employment information must be consistent with PSIP Demographic Data Form, item #7 (EMPLOYMENT TYPE).**

Hospitalization Dates Related to Current Services (Admission and Discharge dates)

*** **Note:** **Hospital admit and discharge dates that are equal (i.e., 07-01-06 to 07-01-06) in box 18 must have an explanation in box 19 (Reserved for Local Use)**

Diagnoses (primary and two others)

Date of Service

Procedures (descriptions)

Patient's Account No.

Name and Address of Facility Where Services Were Rendered

The CMS-1500 section at the top of the form indicating *Medicare, Medicaid, Champus, Group Health Plan, Other,* will only be accepted when *Other* is checked or the section is left blank. If any other box is checked (*Medicare, Medicaid, Group Health Plan, etc.*), the claim will be rejected.

When completing Section Number 24 (A thru K) all lines are to be utilized before going on to another CMS-1500 form.

COUNTY OF LOS ANGELES - DEPARTMENT OF HEALTH SERVICES

NON-COUNTY PHYSICIANS

PHYSICIAN SERVICES FOR INDIGENTS PROGRAM (PSIP) DEMOGRAPHIC DATA FORM

FOR EMS USE ONLY
TRAUMA YES ☐ NO ☐

PATIENT INFORMATION*

COMPLETE ENTIRE CLAIM AND SUBMIT WITH CMS-1500

1. TPS #: _____ 2. SOCIAL SECURITY NUMBER: ☐☐☐☐☐☐☐☐☐

3. PATIENT'S NAME _____
LAST FIRST MIDDLE INITIAL

(1) IF MINOR, PARENT/GUARDIAN: _____
LAST FIRST

4. PLACE OF BIRTH: _____
CITY STATE COUNTRY

5. MOTHER'S MAIDEN NAME: _____

6. ETHNICITY: (CHECK ONE)
☐ (1) WHITE
☐ (2) BLACK
☐ (3) ASIAN/PACIFIC ISLANDER
☐ (4) NATIVE AMERICAN/ESKIMO/ALEUT
☐ (5) HISPANIC
☐ (6) FILIPINO
☐ (7) OTHER

7. EMPLOYMENT TYPE:
☐ (0) UNEMPLOYED
☐ (1) FARMING/FORESTRY/FISHING
☐ (2) LABORERS/HELPERS/CRAFT/ INSPECTION/REPAIR/PRODUCTION/ TRANSPORTATION
☐ (3) SALES/SERVICE
☐ (4) EXECUTIVE ADMINISTRATIVE/MANAGERIAL/ PROFESSIONAL/TECHNICAL/RELATED SUPPORT
☐ (5) OTHER

8: MONTHLY INCOME: $ _____ 9. FAMILY SIZE (COUNT PATIENT AS 1): _____

10. SOURCE OF INCOME:
☐ (0) NONE
☐ (1) GENERAL RELIEF
☐ (2) WAGES
☐ (3) SELF-EMPLOYED
☐ (4) DISABILITY
☐ (5) RETIRED
☐ (6) OTHER, e.g., UNEMPLOYMENT/VA BENEFITS/INTEREST/DIVIDENDS/RENT/ CHILD SUPPORT/ALIMONY, ETC.

PATIENT INFORMATION VERIFICATION

*IF UNABLE TO OBTAIN INFORMATION FROM HOSPITAL, SUBMITTING PHYSICIAN/AGENCY MUST GIVE REASON(S) WHY INFORMATION WAS NOT OBTAINED AND MUST SIGN INDICATING EVERY ATTEMPT WAS MADE:

REASON(S): _____ (26)

SIGNATURE: _____ (27)

PHYSICIAN SERVICES

20. PHYSICIAN FUND:
☐ (1) CONTRACT TRAUMA
☐ (2) NON-CONTRACT EMERGENCY
☐ (3) PEDIATRICS
☐ (4) OBSTETRICS EDD: ☐☐☐

21. SERVICE SETTING:
☐ (1) INPATIENT
☐ (2) EMERGENCY DEPARTMENT
☐ (3) OUTPATIENT/OFFICE VISIT, CHECK ONE OF: ☐ a. PRIMARY CARE ☐ b. SPECIALTY CARE

22. PHYSICIAN'S NAME: _____ STATE LICENSE NO: _____

23. PAYEE NAME: _____ PAYEE TAX ID#: _____

PAYEE ADDRESS: _____

24. DATE BILLED COUNTY: ☐☐☐ CHARGES: $ _____

FOR QUESTIONS REGARDING CLAIM:

25. CONTACT PERSON _____ TELEPHONE NO: ( ) _____

Rev. 06/01/13