



THOMAS L. GARTHWAITE, M.D.  
Director and Chief Medical Officer

FRED LEAF  
Chief Operating Officer

COUNTY OF LOS ANGELES  
DEPARTMENT OF HEALTH SERVICES  
313 N. Figueroa, Los Angeles, CA 90012  
(213) 240-8101

February 10, 2005

The Honorable Board of Supervisors  
County of Los Angeles  
383 Kenneth Hahn Hall of Administration  
500 West Temple Street  
Los Angeles, CA 90012

Dear Supervisors:

**APPROVAL OF A TRAUMA CENTER SERVICE AUGMENTATION AGREEMENT  
WITH ST. FRANCIS MEDICAL CENTER, ADDITIONAL FUNDING FOR THE NON-COUNTY  
PHYSICIAN SERVICES FOR INDIGENTS PROGRAM AND HARBOR-UCLA MEDICAL  
CENTER, AND RELATED APPROPRIATION ADJUSTMENTS**  
(All Districts) (4 Votes)

IT IS RECOMMENDED THAT YOUR BOARD:

1. Approve and instruct the Director of Health Services, or his designee, to offer and sign a Trauma Center Service Augmentation Agreement substantially similar to Exhibit I, with St. Francis Medical Center, following signature by an authorized representative, effective March 1, 2005 through February 28, 2006, for a total maximum amount of \$4.8 million, with delegated authority to extend the Agreement for one year at the written request of St. Francis Medical Center unless the County objects for good cause, upon substantially similar terms and conditions.
2. Approve the allocation and expenditure of up to a maximum amount of \$4.8 million in "Measure B" Trauma Property Assessment funding, including a maximum amount of \$1.9 million for St. Francis Medical Center patient claims as part of the Los Angeles County Trauma Center System, and a Transitional Capacity Development Allowance in an amount not to exceed \$2.9 million.
3. Approve the attached appropriation adjustment to allocate \$3 million in "Measure B" Appropriation For Contingencies funds as follows: \$1.6 million for trauma care and Transitional Capacity Development Allowance services provided by St. Francis Medical Center during Fiscal Year 2004-05, and \$1.4 million in Fiscal Year 2004-05 to backfill a shortfall of other State and local funding needed to maintain the current reimbursement rates for the Non-County Physician Trauma Services for Indigents Program and Emergency Services for Indigents Program at St. Francis Medical Center.

BOARD OF SUPERVISORS

Gloria Molina  
First District

Yvonne Brathwaite Burke  
Second District

Zev Yaroslavsky  
Third District

Don Knabe  
Fourth District

Michael D. Antonovich  
Fifth District

4. Approve the attached appropriation adjustment for a total amount of \$2.3 million which is necessary to reallocate \$1.6 million in "Health Services Designation" funds to augment Harbor-UCLA Medical Center as part of the Los Angeles County Trauma Center System during Fiscal Year 2004-05, and increase related patient care revenues by \$0.7 million to cover costs associated with Salaries & Employee Benefits, Services and Supplies, and Fixed Assets.

PURPOSE/JUSTIFICATION OF THE RECOMMENDED ACTIONS:

Trauma Center Service Augmentation Agreement

Approval of the recommended actions will help ensure the continued viability of the current trauma system in Los Angeles County. Currently, there are fourteen designated trauma centers in Los Angeles County, eleven non-County operated and three County operated, covering a population of over ten million and 4,083 miles, treating over 18,000 major trauma patients annually. With the closure of the Trauma Unit at Martin Luther King/Drew Medical Center (MLK), other trauma centers will need to augment service capability and capacity.

The Board's approval of the Augmentation Agreement is necessary to expand the volume of trauma patients transported to St. Francis Medical Center (SFM) by an estimated 300 patients annually. As the issues at MLK have unfolded over the last year, SFM, which is the closest emergency room (ER) to MLK, has experienced a significant increase in ER and trauma patient volume. Therefore, to ensure that SFM has adequate capacity and capability to handle an additional estimated 300 trauma patients, a one-time start-up allocation, referred to as the Transitional Capacity Development Allowance (TCDA), is being offered to SFM.

Funding for Additional Trauma Care at Harbor-UCLA Medical Center

Additionally, the closure of the MLK Trauma Unit will result in a redirection of an estimated 500 trauma patients to Harbor-UCLA Medical Center (Harbor). Harbor has already taken on approximately 300 additional patients from the southern boundary of MLK in February 2004.

Physician Funding

The Non-County Physician Trauma and Emergency Services for Indigents Program (PSIP) funding is used to provide reimbursement for non-County trauma and emergency physician services at private sector hospitals. Current funding sources for PSIP, for both trauma and other emergency services, will not be sufficient to maintain the current reimbursement fee schedule for all projected Fiscal Year (FY) 2004-05 claims anticipated to be submitted by participating non-County physicians providing services at private hospitals. Failure to sufficiently fund this program will result in the inability of hospitals to maintain physician specialty call panels for trauma centers and emergency departments. Approval of the appropriation adjustment in Recommendation No. 3 will provide necessary funding to maintain the current reimbursement rates for physician trauma services at the non-County trauma hospitals and emergency physician services at SFM under PSIP program.

FISCAL IMPACT/FINANCING:

In order to offer SFM an agreement to augment current capacity and capability, a maximum amount of \$4.8 million in "Measure B" Appropriation For Contingencies (AFC) funds will be used from March 1, 2005 through February 28, 2006, for direct payments, based upon the projected increase in trauma patient volume, and for a TCDA.

For FY 2004-05, the total potential maximum obligation to SFM, with all contingencies and allowances, is \$1.6 million using "Measure B" AFC funding. The total funding for Harbor for FY 2004-05, through reallocation of "Health Services Designation" funds (\$1.6 million) and increased related patient care revenues (\$0.7 million), is \$2.3 million.

The amount of funding for the FY 2004-05 PSIP, provided by Emergency Medical Service Appropriation (EMSA), SB 612 (including prior year fund balance and interest earnings), and Proposition 99 funds, is currently projected to be approximately \$20.4 million. Projected FY 2004-05 expenditure requirements using the current Official County Fee Schedule (OCFS) reimbursement rates is approximately \$27.0 million, resulting in a projected shortfall of \$6.6 million. The \$1.4 million shortfall in funding for trauma physicians at all non-County trauma hospitals and emergency physician services at SFM will be funded using "Measure B" AFC funds.

Upon approval of the recommended actions, the Department of Health Services (DHS or Department) will work with the Chief Administrative Office during the budget process to evaluate and incorporate the necessary budgetary provisions into the FY 2005-06 DHS Budget pertaining to the final eight months of the Trauma Center Service Augmentation agreement with SFM and PSIP funding. The additional funding for Harbor trauma services was included in the January 28, 2005 submission to the Chief Administrative Office for the FY 2005-06 budget request.

FACTS AND PROVISIONS/LEGAL REQUIREMENTS:

Trauma Center Service Augmentation Agreement

On June 24, 2003, the Board approved Trauma Center Service Agreements with ten non-County Trauma Centers for FYs 2003-04 and 2004-05. Funds for these agreements are comprised of "Measure B" funds, SB 612 funds and Proposition 99 funds. On September 21, 2004, the Board approved Trauma Center Service Agreement Amendment No. 1 to increase base hospital funding and allocate additional funds to maintain the existing reimbursement amount to account for diminished State funding.

On November 16, 2004, the Board approved the designation of California Hospital Medical Center (CAL) as a Level II Trauma Center. CAL entered the system in two graduated stages of coverage within a geographic area for trauma patients, with Phase 1 beginning on December 1, 2004 and Phase 2 beginning February 1, 2005 for an estimated annual volume of 1,200 trauma patients. Funding for CAL consisted of reallocated and unallocated "Measure B" funds.

On November 23, 2004, the Board approved the proposed reduction of trauma services at MLK and instructed the Department to negotiate with surrounding hospitals to ensure coverage of the remaining MLK trauma catchment area and an estimated 1,800 patients.

Along with the designation of CAL, the recommended Augmentation Agreement with SFM, and funding for SFM and Harbor will ensure continued coverage of trauma services for Los Angeles County.

Under the Augmentation Agreement, the County shall provide a start up allowance and reimburse SFM for treatment of eligible indigent trauma patients at rates previously approved by the Board under the Trauma Center Service Agreements. Should new rates be negotiated under the Trauma Center Agreements, under the terms of the Augmentation Agreement, the parties have agreed to execute an amendment so that such rates shall apply and be similarly implemented and that the maximum County obligation shall be increased if needed.

#### Physician Funding

In 1987, the California Legislature enacted Chapter 1240, Statutes of 1987, allowing counties to establish an Emergency Medical Services (EMS) fund (Maddy fund - also referred to as SB 612 funds) to compensate physicians and medical facilities for emergency services provided to indigent patients. The funds are derived from additional penalties assessed on fines and bail forfeitures that the courts collect for certain criminal offenses and motor vehicle violations. The formula for fund distribution, including the percentage for the PSIP, is specified in the California Health and Safety Code, Section 1797.98a:

Early in the program, the annual deposits to the County's PSIP exceeded reimbursements, creating a surplus. This reserve fund was \$12.0 million at the end of FY 2000-01. Factors that have reduced this reserve fund to \$0.6 million at the end of FY 2003-04 are: increased physician participation in the reimbursement program; an increase in reimbursement rates prompted by problems maintaining physician call panels for hospital emergency departments and legislation placing a limit on the amount of reserve funds allowed; and decreases in the annual SB 612 and Proposition 99 revenues.

In October 1989, the Governor signed into law AB 75 (Chapter 1331; Statutes of 1989) which contained provisions for the distribution of Proposition 99 Tobacco Tax revenues. AB 75 established the California Healthcare for Indigents Program (CHIP), a program which appropriates Statewide funding for hospitals, physicians and other health services for indigent persons. These funds are allocated to counties based primarily on each county's share of the financial burden of providing health services to those who are unable to pay. AB 75 dictates the portion of these funds that must be allocated to the county's PSIP.

Over the years, Proposition 99 funding for the PSIP steadily decreased, with no funding provided in FY 2002-03 or FY 2003-04. The decline in this revenue source greatly contributed to the increasing use of the SB 612 reserve fund to maintain the OCFS at the current rates. Starting in FY 2001-02, to partially restore diminishing Proposition 99 funds available for the PSIP, the State's budget has included an EMSA allocation, specifically for physician reimbursement of emergency care provided to indigent patients.

The Agreement (Exhibit I) has been approved as to form by County Counsel.

Attachments A through C provide additional information pertaining to the recommended Agreement and required appropriation adjustments.

CONTRACTING PROCESS:

Non-County hospitals executing Trauma Center Service agreements are currently participating in the County's trauma system and satisfy the State and County criteria and condition for such participation.

Any non-County physician providing emergency services to indigent patients at a non-County hospital, including a non-County trauma center, is eligible to participate in the PSIP by completing the FY 2004-05 Conditions of Participation Agreement and the Enrollment Form and by following the policies and procedures included in Exhibit II.

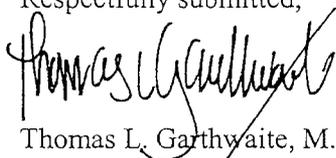
It is not appropriate to advertise these agreements on the Office of Small Business' Countywide Web Site.

IMPACT ON CURRENT SERVICES (OR PROJECTS):

Approval of these actions will ensure the continued viability of, and access to, the current level of trauma and emergency services.

When approved, this Department requires three signed copies of the Board's action.

Respectfully submitted,



Thomas L. Garthwaite, M.D.  
Director and Chief Medical Officer

TLG:ps

Attachments (6)

- c: Chief Administrative Officer
- County Counsel
- Executive Officer, Board of Supervisors
- Auditor-Controller
- Chair, Emergency Medical Services Commission
- Health Care Association of Southern California
- State Department of Health Services

**SUMMARY OF AGREEMENT**

1. TYPE OF SERVICE:

Augmentation of existing trauma center services.

2. AGENCY ADDRESS AND CONTACT PERSON:

St. Francis Medical Center  
3630 East Imperial Highway  
Lynwood, California 90262  
Attention: Dr. Gerald Kozai, President and Chief Executive Officer  
Telephone: (310) 900-7301  
FAX: (310) 900-7390

3. TERM OF AGREEMENT:

Effective March 1, 2005 through February 28, 2006, which may be extended for a maximum of one year beyond the expiration date.

4. FINANCIAL INFORMATION:

For the agreement with SFM, a maximum of \$4.8 million in "Measure B" Appropriation For Contingencies (AFC) funds will be utilized from March 1, 2005 through February 28, 2006, for direct payments, based upon the projected increase in trauma patient volume and for a TCDA.

For FY 2004-05, the total potential maximum obligation to SFM, with all contingencies and allowances, is \$1.6 million using "Measure B" AFC funding. The total funding for Harbor for FY 2004-05, through reallocation of "Health Services Designation" funds (\$1.6 million) and increased related patient care revenues (\$0.7 million), is \$2.3 million.

The amount of funding for the FY 2004-05 PSIP, provided by Emergency Medical Service Appropriation (EMSA), SB 612 (including prior year fund balance and interest earnings), and Proposition 99 funds, is currently projected to be approximately \$20.4 million. Projected FY 2004-05 expenditure requirements using the current Official County Fee Schedule (OCFS) reimbursement rates is approximately \$27.0 million, resulting in a projected shortfall of \$6.6 million. The \$1.4 million shortfall in funding for trauma physicians at all non-County trauma hospitals and emergency physician services at SFM will be funded using "Measure B" AFC funds.

5. GEOGRAPHIC AREA SERVED:

Countywide.

6. RESPONSIBLE FOR MONITORING:

Department of Health Services Emergency Medical Services Agency.

7. APPROVALS:

Local EMS Agency:	Carol Meyer, Director
Contract Administration:	Irene E. Riley, Director
County Council (approval as to use):	Edward A. Morrissey, Deputy County Counsel

LOS ANGELES COUNTY - DEPARTMENT OF HEALTH SERVICES  
 PROPOSED USES OF "MEASURE B" - TRAUMA PROPERTY ASSESSMENT (TPA) FUNDS  
 FISCAL YEAR 2004-05  
 (\$ in millions)

Attachment B

	FY 04-05 <u>Adjusted Budget</u>	+	Proposed <u>Increase/(Decrease)</u>	=	FY 04-05 <u>Proposed Plan</u>
<b>SOURCES</b>					
Beginning Fund Balance	\$ 15.318	(a)	\$ -		\$ 15.318
Current Year Funding	<u>\$ 177.500</u>				<u>\$ 177.500</u>
<b>TOTAL SOURCES</b>	<u>\$ 192.818</u>		<u>\$ -</u>		<u>\$ 192.818</u>
<b>USES</b>					
<u>County DHS</u>					
- Hospital Trauma and Emergency Services Support	\$ 142.612		\$ -		\$ 142.612
- Public Health - Bioterrorism	2.816				2.816
- Emergency Medical Services Agency	<u>1.388</u>				<u>1.388</u>
Subtotal County DHS	<u>\$ 146.816</u>		<u>\$ -</u>		<u>\$ 146.816</u>
<u>Expanded Access</u>					
- Air Transport					
* County Fire	\$ -	(b)			\$ -
* County Sheriff	TBD	(c)			TBD
* City Fire	<u>TBD</u>	(c)			<u>TBD</u>
Subtotal Air Transport	<u>\$ 1.600</u>		<u>\$ -</u>		<u>\$ 1.600</u>
- Helicopter Lease - County Fire	<u>2.000</u>				<u>2.000</u>
Subtotal Expanded Access	<u>\$ 3.600</u>		<u>\$ -</u>		<u>\$ 3.600</u>
<u>Other County - TPA Administration</u>	<u>\$ 1.000</u>		<u>\$ -</u>		<u>\$ 1.000</u>
<u>Private Trauma Contracts</u>					
- Service Claims					
* Base Contract Funding	\$ 11.060	(d)	0.546	(e)	\$ 11.606
* Backfill Funding - Other Revenue Shortfalls	2.200		-		2.200
* Supplemental Contingency Max. Obligation	<u>0.664</u>	(f)	<u>0.109</u>	(g)	<u>0.773</u>
Subtotal	<u>\$ 13.924</u>		<u>\$ 0.655</u>		<u>\$ 14.579</u>
- Lump-Sum Payments	7.940				7.940
- Trauma Center Base Stations (maximum)	3.800		-		3.800
- Transitional Capacity Dev. Allowance	<u>0.420</u>	(h)	<u>0.960</u>	(i)	<u>1.380</u>
Subtotal Private Trauma Contracts - TPA	<u>\$ 26.084</u>		<u>\$ 1.615</u>		<u>\$ 27.699</u>
<u>Private Physician Funding Shortfall</u>	<u>\$ -</u>		<u>\$ 1.400</u>	(j)	<u>\$ 1.400</u>
<b>TOTAL USES</b>	<u>\$ 177.500</u>		<u>\$ 3.015</u>		<u>\$ 180.515</u>
Ending Fund Balance	<u>\$ 15.318</u>		<u>\$ (3.015)</u>		<u>\$ 12.303</u>

**ATTACHMENT C**

**TRAUMA PHYSICIAN SERVICES PROGRAM  
FISCAL YEAR 2004-05  
CONDITIONS OF PARTICIPATION AGREEMENT**

**and**

**PHYSICIAN SERVICES FOR INDIGENTS PROGRAM  
FISCAL YEAR 2004-05  
CONDITIONS OF PARTICIPATION AGREEMENT**

COUNTY OF LOS ANGELES • DEPARTMENT OF HEALTH SERVICES

TRAUMA PHYSICIAN SERVICES PROGRAM

FISCAL YEAR 2004-05  
CONDITIONS OF PARTICIPATION AGREEMENT

SUBMIT TO: AMERICAN INSURANCE ADMINISTRATORS (AIA)  
BOX 34759  
LOS ANGELES, CALIFORNIA 90034-0759

The undersigned physician (hereinafter "Physician") certifies that claims submitted hereunder are for trauma services provided by him/her at a County contract trauma hospital to trauma patients who cannot afford to pay, 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.

Physician acknowledges receipt of a copy of the "Trauma Physician Services Program Billing Procedures" (hereinafter "Billing Procedures"), promulgated by the County of Los Angeles, Department of Health Services, for fiscal year 2004/05, the terms and conditions of which are incorporated herein by reference.

In providing eligible trauma services for the full term of fiscal year 2004/05, Physician hereby agrees to abide by the terms and conditions of Billing Procedures, and certifies that he/she will comply fully with the claiming conditions stated therein; and 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 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

\_\_\_\_\_  
PRIMARY SPECIALTY OF PHYSICIAN

\_\_\_\_\_  
SIGNATURE OF PHYSICIAN

\_\_\_\_\_  
STATE LICENSE NUMBER

\_\_\_\_\_  
DATE

COUNTY OF LOS ANGELES - DEPARTMENT OF HEALTH SERVICES

**PHYSICIAN  
REIMBURSEMENT  
PROGRAMS**

**PROGRAM ENROLLMENT PROVIDER FORM FISCAL YEAR 2004/05**

Completion of Enrollment Form is required annually by each physician

PHYSICIAN NAME: \_\_\_\_\_  
(LAST) (FIRST) (M.I.)

ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ ZIP CODE: \_\_\_\_\_

TELEPHONE NO: ( ) \_\_\_\_\_ CONTACT PERSON: \_\_\_\_\_

PRIMARY SPECIALTY: \_\_\_\_\_ STATE LICENSE NUMBER: \_\_\_\_\_

U.P.I.N.: \_\_\_\_\_ PAYEE TAX I.D. #: \_\_\_\_\_

PAYEE ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP CODE: \_\_\_\_\_

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

GROUP NAME: \_\_\_\_\_

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

COMPANY NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ ZIP CODE: \_\_\_\_\_

TELEPHONE NO: ( ) \_\_\_\_\_ CONTACT PERSON: \_\_\_\_\_

LIST ALL HOSPITALS WHERE MEDICAL SERVICES ARE PROVIDED WITHIN LOS ANGELES COUNTY:

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 (AIA)**  
 BOX 34759  
 LOS ANGELES, CA. 90034-0759

COUNTY OF LOS ANGELES • DEPARTMENT OF HEALTH SERVICES

PHYSICIAN REIMBURSEMENT PROGRAMS

PHYSICIAN REIMBURSEMENT POLICIES

• • • Revised for Fiscal Year 2004/05 • • •

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. Hour Limitation: Reimbursement for emergency services will be limited to the first 48 hours of continuous service and must be provided by a physician on site and in person. EXCEPTION: Trauma physicians providing trauma services at County contract trauma hospitals may bill for trauma physician services provided beyond the 48 hour 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 considered upon appeal and/or provision of applicable operative and/or pathology reports.
  3. Claims determined to be Medi-Cal eligible will be denied.

- 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. Patients 65 years of Age or Older: Unless proof of Medicare denial is provided, e.g., copy of denial of Medicare or Medicare card with Part A only, claims for patients 65 years of age or older will be rejected.
- I. 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 1<sup>st</sup> Procedure and 50% for the 2<sup>nd</sup> through 5<sup>th</sup> Procedures.

### 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 CHIP 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 (i.e., 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 "Wet" or "Stat" 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 Policies 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 CHIP 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)  
Box 34759  
Los Angeles, CA 90034-0759  
ATTN: APPEALS UNIT

FLUSERS:DPEREZIA875:01-02POL.WPD  
06/93

TRAUMA PHYSICIAN SERVICES PROGRAM

BILLING PROCEDURES

• • • Revised for Fiscal Year 2004/05 • • •

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 in the "Department of Health Services' Physician Reimbursement Policies, Revised for Fiscal Year 2004/05", attached as Exhibit "A" and incorporated herein by reference. 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 only valid for trauma services rendered during the period July 1, 2004 through June 30, 2005.

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 the trauma hospital.

## II. PHYSICIAN ELIGIBILITY

- A. The Physician must complete a current fiscal year 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. A copy of the "Conditions of Participation Agreement" and "Program Enrollment Provider Form" are attached hereto as Exhibit "B" and incorporated herein by reference.
- 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 the trauma hospital are not, however, eligible for reimbursement under this claiming process.)

## III. PATIENT ELIGIBILITY/BILLING EFFORTS

Only patients for whom the trauma hospital is required to complete a trauma patient summary ("TPS") form 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, are covered by this claiming process.

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
- (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 reasonable efforts 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 on a claim hereunder, the 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. County is subrogated to any and all legal and equitable rights and causes of action which Contractor has against such trauma patient, his/her responsible relatives, or third-party payers responsible for the patient's medical expenses and County may proceed independently, to extent permitted by law, against such persons or agencies to recover its payment to Contractor. Contractor shall reasonably cooperate with County in these collection efforts.

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, the Physician is reimbursed by a patient or a responsible third party, the Physician shall do one of the following:

- (a) immediately notify the County (see address below) in writing and the Physician's future payment of claims hereunder shall be reduced accordingly. In the event there is not a subsequent submission of a claim for County reimbursement hereunder within one year (to which the payment may be applied as credit), the Physician shall reimburse the County in an amount equal to the amount collected from the patient or third-party payer, but not more than the amount received from the County; or
- (b) immediately notify the County (see address below) in writing of the payment, and reimburse the County in an amount equal to the amount collected from the patient or third-party payer, but not more than 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 detailed explanation for the refund, e.g., received a payment for services from Medi-Cal, etc.

**SUBMIT NOTIFICATION AND/OR REFUND TO:**

County of Los Angeles  
Department of Health Services  
Expenditure Management  
313 North Figueroa Street, Room 505  
Los Angeles, CA 90012  
ATTN: CHIP Program

IV. CONDITIONS OF REIMBURSEMENT

Payment is contingent upon adherence to California Department of Health Services' regulations 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 on and after July 1, 2004 and before July 1, 2005. All claims for services provided during the fiscal year 2004/05 (July 1 through June 30) must be received no later than October 31, 2005. Claims received after the fiscal year deadline has passed will not be paid. Unless sooner terminated, canceled, or amended, this claim process shall expire on October 31, 2005.

VI. REIMBURSEMENT

Except as expressly noted in Paragraph XII, herein below, reimbursement of a valid claim hereunder will be made at 50% of the rate in effect on the date of service, as set forth in 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 Physician's 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 "Fiscal Year 2004/05 Conditions of Participation Agreement" for the current fiscal year Trauma Physician Services Program (sample attached).  
Submit one original signed Agreement to the contracted Claims Adjudicator:

American Insurance Administrators ("AIA")  
Box 34759  
Los Angeles, CA 90034-0759

- B. Complete one HCFA-1500 Form per patient.
- C. Complete one California Healthcare for Indigents Program ("CHIP") Form per patient (sample attached as Exhibit "D"). 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 Instructions for Submission of Claims and Data Collection (attached as Exhibit "C").

VIII. ELECTRONIC BILLING

As an option, the contracted Claims Adjudicator can receive claims electronically. The record layout necessary for electronic submission shall be obtained directly from the contracted Claims Adjudicator at (310) 390-7900, Extension 301.

IX. SUBMIT CLAIM(S) TO COUNTY

American Insurance Administrators (AIA)  
P.O. Box 34759  
Los Angeles, California 90034-0759  
Attention: TRAUMA CLAIMS

X. CLAIM REJECTION AND APPEALS

- A. Revised claims previously rejected for incomplete information must be received by the contracted Claims Adjudicator within twenty (20) calendar days of the rejection letter.
- B. The Physician must submit an appeal of any denied claim within thirty (30) 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 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 - 1 (800) 303-5242 Extension 319

**For Program/Policy Issues, call:**

Emergency Medical Services Agency  
EMS Reimbursement Coordinator  
(323) 890-7521

XII. COUNTY LIABILITY/PAYMENT/SUBROGATION

Payment of any claim under this claiming process is expressly contingent upon the availability of monies specifically allocated by the State of California under Proposition 99 for this fiscal year. To the extent such monies are available in the County's trauma services sub-account, valid claims presented to the County may be paid. Valid claims will be paid in order of their receipt by the County; that is, if a complete and correct claim is received by County, it will have priority over claims subsequently received. If there are unexpected and unencumbered monies remaining in the County's trauma services sub-account after all claims submitted by the County's established deadline have been paid, including, any additional payment required by Paragraph VI, County disposition thereof shall be made in accordance with law.

After the County pays the Physician for services billed hereunder, it is understood that the County is subrogated and assigned to all rights which the Physician may have

against the patient and any third-party payer, and that the County may pursue any such source to recover its expenditures hereunder, using all appropriate means. The Physician shall cooperate with the County in these collection efforts.

### 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. The 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 collection revenue, if any, for which claim has been made under this claiming process.
2. All such records shall be retained by the 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 State or County, upon request, at all reasonable times during such three year period for the purpose 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. If the audit was conducted on a statistically random sample of claims, the dollar amount disallowed shall become a percentage of the total paid on the sample, referred to as the exception rate. The audit exception rate found in the sampled claims reflects, from a statistical standpoint, the overall exception rate potentially possible within the universe of adjudicated claims for that fiscal year. This exception rate shall be applied to the total universe of paid claims which will determine the final reimbursement due to the County.

If an audit of the Physician records is conducted by State or County representatives relating to the services for which claim was made and paid hereunder and findings reveal 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) the 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) the Physician did not

otherwise qualify for reimbursement hereunder, the Physician shall, upon receipt of County billing therefor, remit forthwith to the County the difference between the claim amount paid by the County and the amount of the adjusted billing as determined by the audit.

County also reserves the right to exclude the 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 two million dollars (\$2,000,000) per occurrence.

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.

By utilizing this claiming process, the Physician further certifies that he/she maintains comprehensive auto liability insurance endorsed for all owned, and non-owned vehicles used by him/her and by his/her employees in connection with the professional services for which claim is made, with a combined single limit of at least five hundred thousand dollars (\$500,000) per occurrence.

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

The parties acknowledge the existence of the Health Insurance Portability and Accountability Act of 1996 and its implementing regulations ("HIPAA"). Contractor understands and agrees that, as a provider of medical treatment services, it is a 'covered entity' under HIPAA and, as such, has obligations with respect to the confidentiality, privacy and security of patients' medical information, and must take certain steps to preserve the confidentiality of this information, both internally and externally, including the training of its staff and the establishment of proper procedures for the release of such information, and the use of appropriate consents and authorizations specified under HIPAA.

The parties acknowledge their separate and independent obligations with respect to HIPAA, and that such obligations relate to transactions and code sets, privacy, and security. Contractor understands and agrees that it is separately and independently

responsible for compliance with HIPAA in all these areas and that County has not undertaken any responsibility for compliance on Contractor's behalf. Contractor has not relied, and will not in any way rely, on County for legal advice or other representations with respect to Contractor's obligations under HIPAA, but will independently seek its own counsel and take the necessary measures to comply with the law and its implementing regulations.

CONTRACTOR AND COUNTY UNDERSTAND AND AGREE THAT EACH IS INDEPENDENTLY RESPONSIBLE FOR HIPAA COMPLIANCE AND AGREE TO TAKE ALL NECESSARY AND REASONABLE ACTIONS TO COMPLY WITH THE REQUIREMENTS OF THE HIPAA LAW AND IMPLEMENTING REGULATIONS RELATED TO TRANSACTIONS AND CODE SET, PRIVACY, AND SECURITY. EACH PARTY FURTHER AGREES TO INDEMNIFY AND HOLD HARMLESS THE OTHER PARTY (INCLUDING THEIR OFFICERS, EMPLOYEES, AND AGENTS), FOR ITS FAILURE TO COMPLY WITH HIPAA.

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Rev:06/03

Rev:03/03

COUNTY OF LOS ANGELES • DEPARTMENT OF HEALTH SERVICES

NON-COUNTY PHYSICIANS

INSTRUCTIONS FOR  
SUBMISSION OF CLAIMS AND DATA COLLECTION

• • • Revised for Fiscal Year 2004/05 • • •

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**GENERAL INFORMATION**

Physicians must submit both a HCFA-1500 Form and a CHIP Form for each patient's care if they are claiming reimbursement under the County's private physician California Healthcare for Indigents Program (CHIP). Information from both the CHIP Form and the HCFA-1500 Form are used by the County to comply with State reporting mandates. An original CHIP 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.

**MEDI-CAL ELIGIBILITY:** Procedures continue to be in place to run all FY 2004/05 claims against the State's Medi-Cal Eligibility Tape. Claims which match both patient and month of service will not be paid by the CHIP program. The physician will be provided with the patient's Medi-Cal number so that the physician can bill Medi-Cal. **ALL CLAIMS** should be submitted to American Insurance Administrators.

TRAUMA PHYSICIANS - SUBMIT CLAIMS:

American Insurance Administrators (AIA)  
P.O. Box 34759  
Los Angeles, California 90034-0759  
Attention: **TRAUMA CLAIMS**

ALL OTHER PHYSICIANS--SUBMIT CLAIMS TO:

American Insurance Administrators (AIA)  
P.O. Box 34759  
Los Angeles, California 90034-0759  
Attention: **PSIP CLAIMS**

Contact: AIA Physician Hotline - 1(800) 303-5242

## COMPLETION OF CHIP 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 CHIP 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 HCFA-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:

- Cedars-Sinai Medical Center
- Children's 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 HCFA-1500 FORM

The following HCFA-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 CHIP Form, item #7(EMPLOYMENT TYPE).

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

**\*\*\* Note:** Hospital admit and discharge dates cannot be equal (i.e., 01-01-95 to 01-01-95) unless the patient has expired.

Diagnoses (primary and two others)

Date of Service

Procedures (descriptions)

Patient's Account No.

Name and Address of Facility Where Services Were Rendered

The HCFA-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 HCFA-1500 form.

**NON-COUNTY PHYSICIANS**

**CALIFORNIA HEALTHCARE FOR INDIGENTS PROGRAM (CHIP)**

FOR EMS USE ONLY  
 TRAUMA YES   
 NO

**PATIENT INFORMATION\***

COMPLETE ENTIRE CLAIM AND SUBMIT WITH HCFA-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: ( ) \_\_\_\_\_

COUNTY OF LOS ANGELES • DEPARTMENT OF HEALTH SERVICES

PHYSICIAN SERVICES FOR INDIGENTS PROGRAM

FISCAL YEAR 2004-05  
CONDITIONS OF PARTICIPATION AGREEMENT

SUBMIT TO: AMERICAN INSURANCE ADMINISTRATORS (AIA)  
BOX 34759  
LOS ANGELES, CA 90034-0759

The undersigned physician (hereinafter "Physician") certifies that claims submitted hereunder are for emergency, obstetric, or pediatric services provided by him/her to patients who cannot afford to pay, 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. Physician acknowledges receipt of a copy of the "Physician Services for Indigents Program Billing Procedures" (hereinafter "Billing Procedures"), promulgated by the County of Los Angeles, Department of Health Services, for fiscal year 2004/05, the terms and conditions of which are incorporated herein by reference. Physician hereby agrees to abide by the terms and conditions of Billing Procedures for all claims submitted under this claiming process.

Physician certifies that claims for emergency services shall only be submitted for emergency services provided on the calendar day on which emergency services are first provided and on the immediately following two calendar days; HOWEVER, NO CLAIM SHALL BE MADE FOR SERVICES PROVIDED BEYOND A 48-HOUR PERIOD OF CONTINUOUS SERVICE TO A PATIENT (except for eligible trauma patients provided services at County contract trauma hospitals through a separate program, the Trauma Physician Services Program).

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 expressly acknowledges and accepts that any County liability for claims submitted hereunder is at all times subject to conditions defined in the Billing Requirements, including, but not limited to, (1) availability of monies in the Physician Services for Indigents Program, (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

\_\_\_\_\_  
PRIMARY SPECIALTY OF PHYSICIAN

\_\_\_\_\_  
SIGNATURE OF PHYSICIAN

\_\_\_\_\_  
STATE LICENSE NUMBER

\_\_\_\_\_  
DATE

**PHYSICIAN  
REIMBURSEMENT  
PROGRAMS**

**PROGRAM ENROLLMENT PROVIDER FORM FISCAL YEAR 2004/05**

Completion of Enrollment Form is required annually by each physician

PHYSICIAN NAME: \_\_\_\_\_  
(LAST) (FIRST) (M.I.)

ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ ZIP CODE: \_\_\_\_\_

TELEPHONE NO: ( ) \_\_\_\_\_ CONTACT PERSON: \_\_\_\_\_

PRIMARY SPECIALTY: \_\_\_\_\_ STATE LICENSE NUMBER \_\_\_\_\_

U.P.I.N.: \_\_\_\_\_ PAYEE TAX I.D. # \_\_\_\_\_

PAYEE ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP CODE: \_\_\_\_\_

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

GROUP NAME: \_\_\_\_\_

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

COMPANY NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ ZIP CODE: \_\_\_\_\_

TELEPHONE NO: ( ) \_\_\_\_\_ CONTACT PERSON: \_\_\_\_\_

LIST ALL HOSPITALS WHERE MEDICAL SERVICES ARE PROVIDED WITHIN LOS ANGELES COUNTY:

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 (AIA)**  
**BOX 34759**  
**LOS ANGELES, CA. 90034-0759**

COUNTY OF LOS ANGELES • DEPARTMENT OF HEALTH SERVICES

PHYSICIAN REIMBURSEMENT PROGRAMS

PHYSICIAN REIMBURSEMENT POLICIES

• • • Revised for Fiscal Year 2004/05 • • •

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. Hour Limitation: Reimbursement for emergency services will be limited to the first 48 hours of continuous service and must be provided by a physician on site and in person. EXCEPTION: Trauma physicians providing trauma services at County contract trauma hospitals may bill for trauma physician services provided beyond the 48 hour 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 considered upon appeal and/or provision of applicable operative and/or pathology reports.
  3. Claims determined to be Medi-Cal eligible will be denied.

- 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. Patients 65 years of Age or Older: Unless proof of Medicare denial is provided, e.g., copy of denial of Medicare or Medicare card with Part A only, claims for patients 65 years of age or older will be rejected.
- I. 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 1<sup>st</sup> Procedure and 50% for the 2<sup>nd</sup> through 5<sup>th</sup> Procedures.

### 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 CHIP 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 (i.e., 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 "Wet" or "Stat" 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 Policies 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 CHIP 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)  
Box 34759  
Los Angeles, CA 90034-0759  
ATTN: APPEALS UNIT

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06/03

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. If the audit was conducted on a statistically random sample of claims, the dollar amount disallowed shall become a percentage of the total paid on the sample, referred to as the exception rate. The audit exception rate found in the sampled claims reflects, from a statistical standpoint, the overall exception rate potentially possible within the universe of adjudicated claims for that fiscal year. This exception rate shall be applied to the total universe of paid claims which will determine the final reimbursement due to the County.

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 thereunder, Physician shall, upon receipt of County billing therefor, remit forthwith to the County the difference between the claim amount paid by the County and the amount of the adjusted billing as determined by the audit. 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-limits 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.

By utilizing this claiming process, the Physician further certifies that he/she maintains comprehensive auto liability insurance (written on ISO policy form CA 00 01 or its equivalent) with a limit liability of not less than one million dollars (\$1,000,000) for each accident endorsed for all owned, hired, and non-owned vehicles for "any auto" used by him/her and by his/her employees in connection with the professional services for which claim is made.

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

The parties acknowledge the existence of the Health Insurance Portability and Accountability Act of 1996 and its implementing regulations ('HIPAA'). Contractor understands and agrees that, as a provider of medical treatment services, it is a 'covered entity' under HIPAA and, as such, has obligations with respect to the confidentiality, privacy and security of patients' medical information, and must take certain steps to preserve the confidentiality of this information, both internally and externally, including the training of its staff and the establishment of proper procedures for the release of such information, and the use of appropriate consents and authorizations specified under HIPAA.

The parties acknowledge their separate and independent obligations with respect to HIPAA, and that such obligations relate to transactions and code sets, privacy, and security. Contractor understands and agrees that it is separately and independently responsible for compliance with HIPAA in all these areas and that County has not undertaken any responsibility for compliance on Contractor's behalf. Contractor has not relied, and will not in any way rely, on County for legal advice or other representations with respect to Contractor's obligations under HIPAA, but will independently seek its own counsel and take the necessary measures to comply with the law and its implementing regulations.

CONTRACTOR AND COUNTY UNDERSTAND AND AGREE THAT EACH IS INDEPENDENTLY RESPONSIBLE FOR HIPAA COMPLIANCE AND AGREE TO TAKE ALL NECESSARY AND REASONABLE ACTIONS TO COMPLY WITH THE REQUIREMENTS OF THE HIPAA LAW AND IMPLEMENTING REGULATIONS RELATED TO TRANSACTIONS AND CODE SET, PRIVACY, AND SECURITY. EACH PARTY FURTHER AGREES TO INDEMNIFY AND HOLD HARMLESS THE OTHER PARTY (INCLUDING THEIR OFFICERS, EMPLOYEES, AND AGENTS), FOR ITS FAILURE TO COMPLY WITH HIPAA.

PHYSICIAN SERVICES FOR INDIGENTS PROGRAM

BILLING PROCEDURES

• • • Revised for Fiscal Year 2004/05 • • •

I. INTRODUCTION

Pursuant to provisions of the State of California Welfare and Institutions code ("WIC"), sections 16950, et seq., and Health and Safety Code ("HSC"), sections 1797.98a, et seq., a Physician Services for Indigents Program ("PSIP") has been established by the County of Los Angeles ("County") to provide reimbursement to private physicians ("Physician") for certain professional services that have been rendered in Los Angeles County to eligible indigent patients. Professional physician services herein referred to are limited to emergency services as defined in WIC, section 16953; obstetric services as defined in WIC, section 16905.5; and pediatric services as defined in WIC, section 16907.5.

Professional physician services which can be reimbursed under this claiming process are additionally restricted as prescribed by the County, with such restrictions subject to revision from time to time. Current County physician reimbursement restrictions are set forth in "Department of Health Services' Physician Reimbursement Policies, Revised for Fiscal Year 2004/05", attached hereto and incorporated herein by reference. The County has discretion to revise such policies from time to time as deemed necessary or appropriate and if approved by the Board of Supervisors.

In no event may this claiming process be used by Physician if his/her services are included in whole or in part in hospital or physician services claimed by a hospital or by Physician under a separate formal contract with County. Nor may this claiming process be used if Physician has previously billed County for his/her emergency, obstetric, or pediatric services under any other claiming process established by County.

This document defines the procedures which must be followed by Physician in seeking reimbursement under this Program. Submission of a claim by Physician under these procedures establishes (1) a contractual relationship between the County and Physician covering the services provided and (2) signifies Physician's acceptance of all terms and conditions herein.

These claiming procedures are effective July 1, 2004; are only valid for covered services to the extent that monies are available therefor; and are subject to revisions as required by State laws and regulations and County requirements. This claiming process may not be used by a physician if he or she is an employee of the hospital.

## II. PHYSICIAN ELIGIBILITY

- A. Physician must complete a current fiscal year Physician Services for Indigents Program "Conditions of Participation Agreement" and "Program Enrollment Provider Form" and provide them to the County's Emergency Medical Services ("EMS") Agency in care of the contracted Claims Adjudicator (see address on page 5). Physician claims will not be accepted if said Agreement is not on file with the EMS Agency.
- B. Physicians who provide emergency services to eligible patients in a Los Angeles County (1) basic or comprehensive emergency department of a licensed general acute care hospital, (2) standby emergency department that was in existence on January 1, 1989 in a small and rural hospital as defined in HSC, section 1188.855, or (3) site approved by the County prior to January 1, 1990, as a paramedic receiving station for the treatment of patients with emergency medical conditions, may submit claims hereunder, if all the following conditions are met:
1. Emergency services are provided in person, on site, and in an eligible service setting.
  2. Emergency services are provided on the calendar day on which emergency services are first provided, and on the immediately following two calendar days, not to exceed a 48-hour period of continuous service.

Physician employees of the hospital are not, however, eligible for reimbursement under this claiming process.

- C. Physicians who provide medically necessary obstetric or pediatric services to an eligible patient in a hospital, emergency department, or private office located in Los Angeles County, other than a hospital, emergency department or office owned or operated by the County, may submit a claim hereunder. However, no physician may submit a claim for services provided in a primary care clinic which receives funding under provisions of Chapter 1331, Statutes of 1989.
- D. An emergency physician and surgeon or an emergency physician group with a gross billings arrangement with a hospital located in Los Angeles County shall be entitled to receive reimbursement for services provided in that hospital, if all of the following conditions are met:
1. The services are provided in a basic or comprehensive general acute care hospital emergency department.
  2. The physician and surgeon is not an employee of the hospital.
  3. All provisions of Section III of these Billing Procedures are satisfied, except that payment to the emergency physician and surgeon, or an emergency physician group, by a hospital pursuant to a gross billings arrangement shall not be interpreted to mean that payment for a patient is made by a responsible third party.

4. Reimbursement is sought by the hospital or the hospital's designee, as the billing and collection agent for the emergency physician and surgeon or an emergency physician group.

For the purposes of this section, a "gross billings arrangement" is an arrangement whereby a hospital serves as the billing and collection agent for the emergency physician and surgeon, or an emergency physician group, and pays a percentage of the emergency physician and surgeon's or group's billings for all patients.

### III. PATIENT ELIGIBILITY/BILLING EFFORTS

Only 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 federal government, including Medi-Cal, are covered by this claiming process.

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

- (a) patients for whom 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 Physician has billed all possible payment sources, but has not received reimbursement for any portion of the amount billed; and
- (c) either of the following has occurred:
  1. A period of not less than three (3) months has passed from the date Physician billed the patient or responsible third party, during which time Physician has made reasonable efforts to obtain reimbursement and has not received payment for any portion of the amount billed.
  2. 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. County is subrogated to any and all legal and equitable rights and causes of action which Contractor has against such trauma patient, his/her responsible relatives, or third-party payers responsible for the patient's medical expenses and County may proceed independently, to extent permitted by law, against such persons or agencies to recover its payment to Contractor. Contractor shall reasonably cooperate with County in these collection efforts.

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 do one of the following:

- (a) immediately notify the County (see address below) in writing and Physician's future payment of claims hereunder shall be reduced accordingly. In the event there is not a subsequent submission of a claim for County reimbursement hereunder within one year (to which the payment may be applied as a credit), Physician shall reimburse the County in an amount equal to the amount collected from the patient or third-party payer, but not more than the amount received from the County; or
- (b) immediately notify the County (see address below) in writing of the payment, and reimburse the County in an amount equal to the amount collected from the patient or third-party payer, but not more than 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  
Fiscal Management  
313 North Figueroa Street, Room 505  
Los Angeles, CA 90012

**IV. CONDITIONS OF REIMBURSEMENT**

Payment is contingent upon adherence to California Department of Health Services regulations 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 on and after July 1, 2004 and through June 30, 2005. All claims for services provided during the fiscal year 2004/2005 (July 1 through June 30) must be received by County's Claim Adjudicator no later than October 31, 2005. Claims received after this fiscal year deadline has passed will not be paid. Unless sooner terminated, canceled, or amended, this claim process shall expire on October 31, 2005.

VI. REIMBURSEMENT

Except as expressly noted in Paragraph XII, herein below, reimbursement of a valid claim hereunder will be made at 34% of the rate in effect on the date of service, as set forth in 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 Physician's 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 "Fiscal Year 2004-2005 Conditions of Participation Agreement" for the current fiscal year Trauma Physician Services Program (sample attached). Submit one original signed Agreement to the contracted Claims Adjudicator:

American Insurance Administrators (AIA)  
Box 34759  
Los Angeles, CA 90034-0759

- B. Complete one HFCA-1500 Form per patient.

- C. Complete one California Healthcare for Indigents Program ("CHIP") 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 Instructions for Submission of Claims and Data Collection which are attached.

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 (310) 390-7900, Extension 301.

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

American Insurance Administrators  
Box 34759  
Los Angeles, CA 90034-0759

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.

- B. The Physician must submit an appeal of any denied claim within thirty (30) 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 appeals shall be prepared and sent in accordance with the directions set forth in the Physician Reimbursement Policies.

XI. INFORMATION CONTACTS

For Status of Claims, call:

AIA Physician Hotline - 1 (800) 303-5242

For Program/Policy Issues, call:

Emergency Medical Services Agency  
EMS Reimbursement Coordinator  
(323) 890-7521

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 under the Physician Services for Indigents Program, and until such available monies are exhausted, 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.

After the County pays Physician for services billed hereunder, it is understood that County is subrogated and assigned to all rights which the Physician may have against the patient and any third-party payer, and that the County may pursue any such source to recover its expenditures hereunder, using all appropriate means. The Physician shall cooperate with the County in these collection efforts.

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 the Physician services to the patient.

COUNTY OF LOS ANGELES • DEPARTMENT OF HEALTH SERVICES

NON-COUNTY PHYSICIANS

INSTRUCTIONS FOR  
SUBMISSION OF CLAIMS AND DATA COLLECTION

• • • Revised for Fiscal Year 2004/05 • • •

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GENERAL INFORMATION

Physicians must submit both a HCFA-1500 Form and a CHIP Form for each patient's care if they are claiming reimbursement under the County's private physician California Healthcare for Indigents Program (CHIP). Information from both the CHIP Form and the HCFA-1500 Form are used by the County to comply with State reporting mandates. An original CHIP 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.

**MEDI-CAL ELIGIBILITY:** Procedures continue to be in place to run all FY 2004/05 claims against the State's Medi-Cal Eligibility Tape. Claims which match both patient and month of service will not be paid by the CHIP program. The physician will be provided with the patient's Medi-Cal number so that the physician can bill Medi-Cal. **ALL CLAIMS** should be submitted to American Insurance Administrators.

TRAUMA PHYSICIANS - SUBMIT CLAIMS:

American Insurance Administrators (AIA)  
P.O. Box 34759  
Los Angeles, California 90034-0759  
Attention: **TRAUMA CLAIMS**

ALL OTHER PHYSICIANS--SUBMIT CLAIMS TO:

American Insurance Administrators (AIA)  
P.O. Box 34759  
Los Angeles, California 90034-0759  
Attention: **PSIP CLAIMS**

Contact: AIA Physician Hotline - 1(800) 303-5242

## COMPLETION OF CHIP 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 CHIP 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 HCFA-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/submitted 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:

Cedars-Sinai Medical Center  
Children's 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 HCFA-1500 FORM

The following HCFA-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 CHIP Form, item #7(EMPLOYMENT TYPE).

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

\*\*\* Note: Hospital admit and discharge dates cannot be equal (i.e., 01-01-95 to 01-01-95) unless the patient has expired.

Diagnoses (primary and two others)

Date of Service

Procedures (descriptions)

Patient's Account No.

Name and Address of Facility Where Services Were Rendered

The HCFA-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 HCFA-1500 form.

**NON-COUNTY  
PHYSICIANS**

**CALIFORNIA HEALTHCARE FOR INDIGENTS PROGRAM (CHIP)**

FOR EMS USE ONLY  
 TRAUMA YES   
 NO

**PATIENT INFORMATION\***

COMPLETE ENTIRE CLAIM AND SUBMIT WITH HCFA-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  (4) NATIVE AMERICAN/ESKIMO/ALEUT  (7) OTHER  
 (2) BLACK  (5) HISPANIC  
 (3) ASIAN/PACIFIC ISLANDER  (6) FILIPINO

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

8. MONTHLY INCOME: \$

9. FAMILY SIZE (COUNT PATIENT AS 1):

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

**PATIENT INFORMATION VERIFICATION**

REASON(S): \_\_\_\_\_ (26)  
 \_\_\_\_\_  
 SIGNATURE: \_\_\_\_\_ (27)

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:

**PHYSICIAN SERVICES**

20. PHYSICIAN FUND:  (1) CONTRACT TRAUMA  (3) PEDIATRICS  
 (2) NON-CONTRACT EMERGENCY  (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: ( ) \_\_\_\_\_

COUNTY OF LOS ANGELES  
REQUEST FOR APPROPRIATION ADJUSTMENT

DEPT'S. No.

DEPARTMENT OF Health Services

February 7, xx 2005

AUDITOR-CONTROLLER.

THE FOLLOWING APPROPRIATION ADJUSTMENT IS DEEMED NECESSARY BY THIS DEPARTMENT. WILL YOU PLEASE REPORT AS TO ACCOUNTING AND AVAILABLE BALANCES AND FORWARD TO THE CHIEF ADMINISTRATIVE OFFICER FOR HIS RECOMMENDATION OR ACTION.

ADJUSTMENT REQUESTED AND REASONS THEREFOR

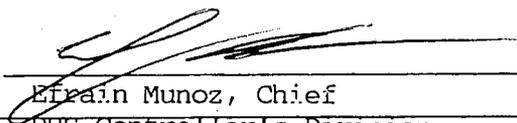
4-VOTE

Please see attached for details.

Justification:

Approve the appropriation adjustment to allocate \$8.2 million in Measure B Appropriation for Contingencies funds as follows: \$1.6 million for trauma care and Transitional Capacity Development Allowance service provided by St. Francis Medical Center during Fiscal Year (FY) 2004-05 and \$6.6 million in FY 2004-05 to backfill a shortfall of other State and local funding needed to maintain the current reimbursement rates for the Non-County Physician Trauma and Emergency Services for Indigents (PSIP) program.

EM:br  
02/07/05

  
Efraim Munoz, Chief

DHS-Controller's Division

CHIEF ADMINISTRATIVE OFFICER'S REPORT

REFERRED TO THE CHIEF ADMINISTRATIVE OFFICER FOR

ACTION

RECOMMENDATION

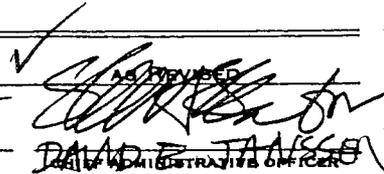
✓



APPROVED AS REQUESTED

February 11 2005

APPROVED (AS REVISED):

  
DAVID J. JANSEN  
CHIEF ADMINISTRATIVE OFFICER

76R 352M 11/83

COUNTY OF LOS ANGELES  
REQUEST FOR APPROPRIATION ADJUSTMENT

DEPT'S. No.

DEPARTMENT OF Health Services

February 7, 2005

AUDITOR-CONTROLLER.

THE FOLLOWING APPROPRIATION ADJUSTMENT IS DEEMED NECESSARY BY THIS DEPARTMENT. WILL YOU PLEASE REPORT AS TO ACCOUNTING AND AVAILABLE BALANCES AND FORWARD TO THE CHIEF ADMINISTRATIVE OFFICER FOR HIS RECOMMENDATION OR ACTION.

ADJUSTMENT REQUESTED AND REASONS THEREFOR

4-VOTE

Please see attached for details.

Justification:

This appropriation adjustment is necessary to reallocate \$1.6 million in "Health Services Designation" funds to augment Harbor-UCLA Medical Center as part of the Los Angeles County Trauma Center System (LACTCS) during FY 2004-05 and increase related patient care revenues by \$0.7 million to cover associated Salaries & Employee Benefits, Services & Supplies and Fixed Assets costs.

EM:mc  
02/07/05

  
Efrain Munoz, Chief  
DHS-Controller's Division

CHIEF ADMINISTRATIVE OFFICER'S REPORT

REFERRED TO THE CHIEF ADMINISTRATIVE OFFICER FOR

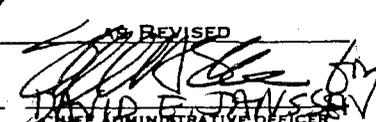
ACTION

APPROVED AS REQUESTED

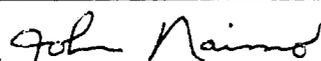
AS REVISED

RECOMMENDATION

February 11, 2005

  
DAVID E. JANSSEN  
CHIEF ADMINISTRATIVE OFFICER

AUDITOR-CONTROLLER BY

  
John Naimo

APPROVED (AS REVISED):  
BOARD OF SUPERVISORS

Contract # \_\_\_\_\_

TRAUMA CENTER SERVICE  
AUGMENTATION AGREEMENT

THIS AGREEMENT is made and entered into this \_\_\_\_\_ day  
of \_\_\_\_\_, 2005,

by and between COUNTY OF LOS ANGELES  
(hereafter "County"),

and ST. FRANCIS MEDICAL CENTER  
(hereafter "Contractor").

WHEREAS, various general acute care hospitals located within Los Angeles County have been identified by County as hospitals which are uniquely staffed and equipped to provide appropriate care to emergency patients who suffer major trauma; and

WHEREAS, the parties hereto have previously entered into a written agreement entitled "TRAUMA CENTER SERVICE AGREEMENT", dated June 24, 2003, and further identified as County Agreement No. H-300376, as amended by Amendment No. 1, dated September 21, 2004; and

WHEREAS, Contractor, by virtue of the parties' execution of County Agreement No. H-300376, is a County designated Trauma Center; and

WHEREAS, Contractor is willing to accept and care for an additional estimated three hundred (300) trauma patients on an annual basis at hospital under County's advanced trauma system as a result of revisions to the County Trauma System to expand the geographical catchment area for trauma patients to be transported to Contractor; and

WHEREAS, the County and Contractor have agreed that the estimated volume of three hundred (300) additional patients described herein is above and beyond the Contractor's Fiscal Year 2004-05 anticipated volume of one thousand three hundred forty-eight (1,348) trauma patients based on Fiscal Year 2003-04 volume; and

WHEREAS, this Agreement establishes funding available to Contractor for certain services performed during the term of this Agreement in accordance with the terms and conditions herein; and

WHEREAS, Contractor has agreed to use its best efforts to maintain continuous participation as a County-designated Trauma Center during the term of this Agreement; and

WHEREAS, County has authorized the Director of Health Services, or his designee, to enter into one or more written amendments as set forth herein; and

WHEREAS, the Agreement is authorized by Health and Safety Code sections 1797.204, 1797.252, 1798.165, and 1798.170, Government Code section 26227, as well as by provisions of WIC section 16946 and Title 22, California Code of Regulations, section 100255.

NOW, THEREFORE, the parties agree as follows:

1. TERM: This Agreement shall commence effective March 1, 2005, and unless terminated sooner in accordance with the TERMINATION Paragraphs of the STANDARD TERMS AND CONDITIONS hereunder and County Agreement H-300376, it shall remain in full force and effect until February 28, 2006, and may be

extended for one (1) year until February 28, 2007, at the written request of Contractor unless County objects for good cause. Good cause shall include but not be limited to the determination that Contractor would have treated no more than 1,348 eligible trauma patients during the term of this Agreement ending February 28, 2006. This determination shall be the result of the County's reasonable projection of Contractor's trauma volume based on available data for eligible trauma patients treated for such period.

Notwithstanding any other provision herein, either party may terminate this Agreement for convenience with sixty (60) days prior advance notice to the other as set forth in Paragraph 1.D. of the County Agreement No. H-300376.

2. STANDARD TERMS AND CONDITIONS: Except as set forth in this Agreement, and except sections 1.A. of County Agreement No. H-300376, and I.4, II, III, and IV of Exhibit B, the parties agree that all other terms and conditions as set forth in the provisions of County Agreement No. H-300376, any Amendments, and any Exhibits and Attachments thereto, shall be incorporated herein by reference. Contractor hereby acknowledges that it shall adhere to all such terms and conditions under this Agreement.
3. CONTINUATION OF TRAUMA SERVICES: The parties anticipate that a replacement Agreement or extension will be negotiated by the parties to continue trauma services performed under

County Agreement No. H-300376 upon its expiration. To the extent such Agreement is not extended or a new replacement Agreement is not negotiated between the parties thereto, the parties shall continue to perform their respective obligations as set forth under County Agreement H-300376 as part of this Agreement. Regardless of the expiration of County Agreement No. H-300376, the terms and conditions as set forth in the provisions of such Agreement, any Amendments, and any Exhibits and Attachments thereto, shall be incorporated herein as part of this Agreement.

4. REPLACEMENT/ADDITIONAL TRAUMA AUGMENTATION TERMS: In addition to or as a replacement to the terms and conditions set forth in County Agreement No. H-300376 and any amendments thereto, the parties agree to the following provisions:

A. ADDITIONAL SPECIFIC RESPONSIBILITIES OF CONTRACTOR:

Contractor shall furnish Trauma Center services to an additional estimated three hundred (300) patients in need thereof who are delivered, or present themselves, to Contractor during the term of this Agreement as a result of revisions to County's advanced trauma system to expand the geographical catchment area for trauma patients to be transported to Contractor.

B. ADDITIONAL GENERAL INSURANCE REQUIREMENTS: In any event, Contractor may satisfy the insurance coverage

requirements specified in County Agreement H-300376, Paragraph 7, SPECIFIC INSURANCE COVERAGE REQUIREMENTS, incorporated herein by reference, by providing evidence of Contractor's self-insurance program, as described herein below. Such evidence shall be provided in a formal declaration (on Contractor's letterhead, if available) that declares Contractor is self-insured for the type and amount of coverage as described in County Agreement H-300376, Paragraph 7, SPECIFIC INSURANCE COVERAGE REQUIREMENTS, incorporated herein by reference. Contractor's declaration may be in the form of a corporate officer or an authorized principal of Contractor. The statement also must identify which required coverages are self-insured and which are commercially insured. Contractors who are self-insured for workers compensation must provide a copy of their "Certificate of Consent to Self-Insure" issued by the State in which services are provided. Further, Contractor's self-insurance program must be reviewed and approved by County's Risk Manager prior to the effective date of this Agreement.

5. REPLACEMENT FUNDING: County has allocated a maximum total amount of \$4.8 million for the term of this Agreement to be paid as follows:

- A. TRAUMA: This funding is intended to provide full reimbursement for an estimated three hundred (300) trauma patients for a twelve-month period during the term of this Agreement, at the rates set forth in subparagraphs I.3.A.(4), (5) and (6) of Exhibit B (reference County Agreement No. H-300376), above and beyond one thousand three hundred forty-eight (1,348) trauma patients, utilizing Fiscal Year 2003-04 volume, at a total amount not to exceed \$1.6 million. This maximum total obligation may be increased up to an additional amount not to exceed \$327,864. To the extent the parties under County Agreement No. H-300376 negotiate and agree to new rates other than those set forth in subparagraphs I.3.A.(4), (5) and (6) of such agreement, then the new rates shall apply for payment for services under this Agreement, and the dollar amounts set forth in the preceding two sentences shall be increased by the percentage increase in the new rates over the rates set forth in County Agreement H-300376. The specific dollar amounts shall be set forth in an amendment of this Agreement duly authorized and executed by the Contractor and the Director or his designee.
- B. FUNDING FOR TRANSITIONAL CAPACITY ALLOWANCE: A one-time start-up allocation, not to exceed \$2,880,000 as

set forth herein, will ensure that Contractor will have appropriate capacity for trauma patients during the period of this Agreement.

To seek to ensure availability of anticipated trauma care, County shall accept from Contractor up to forty (40) patients per month into a County-operated hospital during the period of this Agreement. Should the County be at such capacity that it is unable to accept such patients, a per diem of \$1,500 per day, for a maximum of four (4) days per patient for hospital reimbursement, shall be paid to Contractor for eligible indigent patients (as defined in County Agreement No. H-300376, Exhibit B, Section I. ELIGIBLE INDIGENT TRAUMA CARE). However, this maximum total obligation shall decrease an amount of \$6,000 for every patient accepted by a County-operated hospital during the term of this Agreement. Claims for reimbursement as set forth herein shall include a completed UB-92 form with timely submission to the County's Emergency Medical Services Agency, and shall be paid in accordance with the terms of the County Agreement No. H-300376, as amended.

Patients who Contractor wishes the County to accept for transfer from Contractor shall be presented to the County's Medical Alert Center (MAC) for

transfer. Any patient not presented through the MAC at time of service shall not be eligible for reimbursement.

In addition, the County's MAC shall assist Contractor by facilitating the transfer of complex orthopedic and maxillo-facial trauma patients into the County-operated trauma centers within the capacity and/or capability of these trauma centers. Any transfer of such patients shall count towards the transfer of 40 patients per month as set forth above.

Nothing in this Agreement shall be construed as to limit the County from accepting in excess of forty (40) patients per month from Contractor should capacity be available in accordance with existing County EMS transfer policies and procedures.

Notwithstanding any other provision in this Agreement, Contractor may transfer patients to any County-operated acute care facility which is currently licensed under section 1250 et seq. of the California Health and Safety Code.

6. REPLACEMENT NOTICES: Any and all notices required, permitted, or desired to be given hereunder by one party to the other shall be in writing and shall be delivered to the other party personally or by United States mail, certified or registered postage prepaid return receipt requested, to

the parties at the following addresses and to the attention of the persons named. County's Director shall have the authority to issue all notices which are required or permitted by County hereunder. Addresses and persons to be notified may be changed by a party by giving at least ten (10) calendar days prior written notice thereof to the other.

A. Notices to County shall be addressed as follows:

(1) Department of Health Services  
Emergency Medical Systems Division  
5555 Ferguson Drive, Suite 220  
Commerce, California 90022

Attention: Director

(2) Department of Health Services  
Contracts and Grants Division  
313 North Figueroa Street  
Sixth Floor - East  
Los Angeles, California 90012

Attention: Division Chief

B. Notice to Contractor shall be addressed as follows:

(1) St. Francis Medical Center  
3630 E. Imperial Hwy  
Lynwood, CA 90262

Attention: Chief Executive Officer

IN WITNESS WHEREOF , the Board of Supervisors of the County of Los Angeles has caused this Agreement to be subscribed by its

/

/

/

Director of Health Services and Contractor has caused this Agreement to be subscribed in its behalf by its duly authorized officer, the day, month, and year first above written.

COUNTY OF LOS ANGELES

By

\_\_\_\_\_  
Thomas L. Garthwaite, M.D.  
Director and Chief Medical Officer

\_\_\_\_\_  
ST. FRANCIS MEDICAL CENTER  
Contractor

By

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Title

\_\_\_\_\_  
Date

(AFFIX CORPORATE SEAL HERE)

APPROVED AS TO FORM  
BY THE OFFICE OF THE COUNTY COUNSEL

APPROVED AS TO CONTRACT  
ADMINISTRATION:

Department of Health Services

By

\_\_\_\_\_  
Irene E. Riley, Director  
Contract Administration

AGREECD3768.PS  
ps:02/09/05

COUNTY OF LOS ANGELES  
REQUEST FOR APPROPRIATION ADJUSTMENT

DEPT'S. No.

DEPARTMENT OF Health Services

February 7, 2005

AUDITOR-CONTROLLER.

THE FOLLOWING APPROPRIATION ADJUSTMENT IS DEEMED NECESSARY BY THIS DEPARTMENT. WILL YOU PLEASE REPORT AS TO ACCOUNTING AND AVAILABLE BALANCES AND FORWARD TO THE CHIEF ADMINISTRATIVE OFFICER FOR HIS RECOMMENDATION OR ACTION.

ADJUSTMENT REQUESTED AND REASONS THEREFOR

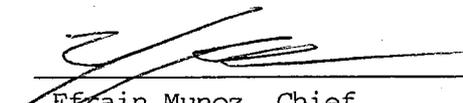
4-VOTE

Please see attached for details.

Justification:

This appropriation adjustment is necessary to reallocate \$1.6 million in "Health Services Designation" funds to augment Harbor-UCLA Medical Center as part of the Los Angeles County Trauma Center System (LACTCS) during FY 2004-05 and increase related patient care revenues by \$0.7 million to cover associated Salaries & Employee Benefits, Services & Supplies and Fixed Assets costs.

EM:mr  
02/07/05

  
Efrain Munoz, Chief  
DHS-Controller's Division

CHIEF ADMINISTRATIVE OFFICER'S REPORT

REFERRED TO THE CHIEF ADMINISTRATIVE OFFICER FOR

ACTION

APPROVED AS REQUESTED

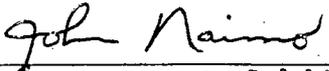
AS REVISED

RECOMMENDATION

February 11, 2005

  
DAVID E. JARVIS  
CHIEF ADMINISTRATIVE OFFICER

AUDITOR-CONTROLLER BY

  
FEB. 10 2005

APPROVED (AS REVISED):  
BOARD OF SUPERVISORS

19

No. 258

BY

DEPUTY COUNTY CLERK

DEPARTMENT OF HEALTH SERVICES  
BUDGET ADJUSTMENT  
FISCAL YEAR 2004-05

(4-VOTES)

SOURCES:

Coastal Area MN1-HH-60020-9433 Medi-Cal Revenue	\$ 184,000
Coastal Area MN1-HH-60020-9435 Medicare Revenue	84,000
Coastal Area MN1-HH-60020-9423 Self-Pay Revenue	29,000
Coastal Area MN1-HH-60020-9419 Insurance Revenue	382,000
Coastal Area MN1-HH-60020-9461 Other Revenue	3,000
SB 855 Enterprise Fund Designation for DHS MN2-HS-60070-3085	1,604,000
Coastal Area (H/UCLA Medical Center) Operating Transfers In MN1-HH-60020-9911	1,604,000

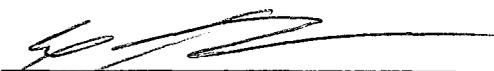
Total \$ 3,890,000

USES:

Coastal Area MN1-HH-60020-1000 Salaries & EBs	\$ 778,000
Coastal Area MN1-HH-60020-2000 Services & Supplies	1,194,000
Coastal Area MN1-HH-60020-6030 Fixed Assets - Equipment	314,000
SB 855 Enterprise Fund Operating Transfers Out MN2-HS-60070-6100	1,604,000

Total \$ 3,890,000

NOTED AND APPROVED

  
Efrain Munoz, Chief  
DHS-Controller's Division

*John Naimo*

BA# 258

FEB. 10, 2005



2/11/05

COUNTY OF LOS ANGELES  
REQUEST FOR APPROPRIATION ADJUSTMENT

DEPT'S. No.

DEPARTMENT OF Health Services

February 07, 2005

AUDITOR-CONTROLLER.

THE FOLLOWING APPROPRIATION ADJUSTMENT IS DEEMED NECESSARY BY THIS DEPARTMENT. WILL YOU PLEASE REPORT AS TO ACCOUNTING AND AVAILABLE BALANCES AND FORWARD TO THE CHIEF ADMINISTRATIVE OFFICER FOR HIS RECOMMENDATION OR ACTION.

ADJUSTMENT REQUESTED AND REASONS THEREFOR

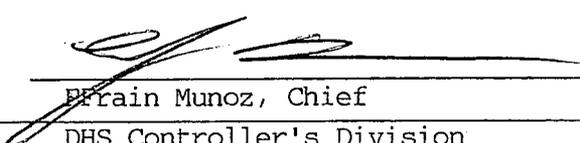
4-VOTE

Please see attached for details.

Justification:

Approve the appropriation adjustment to allocate \$3.0 million in Measure B Appropriation for Contingencies funds as follows: \$1.6 million for Trauma Care and Transitional Capacity Development Allowance services provided by St. Francis Medical Center during Fiscal Year (FY) 2004-05 and \$1.4 million to backfill a shortfall of other State and local funding needed to maintain the current reimbursement rates for the Non-County Physician Trauma Services for Indigents Program and the Emergency Services for Indigents Program at St. Francis Medical Center in FY 2004-05.

EM:br  
02/07/05

  
Brian Munoz, Chief

DHS Controller's Division

CHIEF ADMINISTRATIVE OFFICER'S REPORT

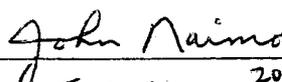
REFERRED TO THE CHIEF ADMINISTRATIVE OFFICER FOR—

ACTION

✓

RECOMMENDATION

AUDITOR-CONTROLLER BY

  
FEB 16 2005

No. 261

APPROVED AS REQUESTED

February 17 2005

AS REVISED

  
DAVID E. JANSSEN  
CHIEF ADMINISTRATIVE OFFICER

APPROVED (AS REVISED):  
BOARD OF SUPERVISORS

19

BY

DEPUTY COUNTY CLERK

DEPARTMENT OF HEALTH SERVICES  
BUDGET ADJUSTMENT  
FISCAL YEAR 2004-05

(4-VOTES)

SOURCES:

Measure B Special Tax Fund  
Appropriation for Contingency  
BW9-HS-~~41017~~-3303 \$ 3,000,000

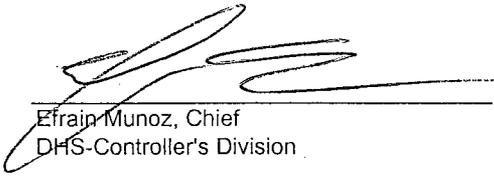
Total \$ 3,000,000

USES:

Measure B Special Tax Fund  
Services and Supplies  
BW9-HS-41017-2000 \$ 3,000,000

Total \$ 3,000,000

NOTED AND APPROVED

  
Efraim Munoz, Chief  
DHS-Controller's Division

John Naimo

Feb. 16, 2005

  
2/17/05