EMERGENCY MEDICAL SERVICES AGENCY
LOS ANGELES COUNTY

Los Angeles County
Board of Supervisors

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Cathy Chidester
Director

William Koenig, MD
Medical Director

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Santa Fe Springs, CA 90670

Tel: (562) 347-1500
Fax: (562) 941-5835

To improve health through leadership, service and education

June 12, 2013

TO: Participating Physicians

FROM: Cathy Chidester
Director

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

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

Enrollment/Conditions of Participation

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

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

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

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

Reimbursement Rate

- The reimbursement rate for services remains at 100% of Medicare allowable Area 18 to include patient copayment amount of twenty percent (20%), not to exceed billed charges.

Claim Period

- Claims may only be submitted for eligible services provided during the effective term of the IHP Agreement.

The following PSIP enrollment documents are attached to this letter:

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

KEY INFORMATIONAL POINTS IN THE ABOVE-REFERENCED DOCUMENTS:

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

-- Physician must be enrolled in the Program before any claims will be processed. The enrollment document may be submitted with the first claim submission.

-- All information on the CMS-1500 and the PSIP Demographic Data Form must be completed in accordance with the instructions outlined in the attached documents. Incomplete, illegible, or inaccurate information will result in the claim being rejected before any adjudication occurs.

-- The following facilities are current IHP contractors: California Hospital Medical Center, Downey Regional Medical Center, Lakewood Regional Medical Center, Long Beach Memorial Medical Center, Memorial Hospital of Gardena, Prime HealthCare Centinela, LLC, dba Centinela Hospital Medical Center, St. Francis Medical Center, and White Memorial Medical Center.

-- Enrollment forms and physician claims should be mailed directly to the County's Contract Claims Adjudicator:

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

Thank you for your participation in the Physician Services for Indigents Program.

CC:AM

Enclosures

COUNTY OF LOS ANGELES • DEPARTMENT OF HEALTH SERVICES

PHYSICIAN REIMBURSEMENT PROGRAM

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

Completion of Enrollment Form is required by each physician

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

Address: _____ City: _____ Zip Code: _____

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

E-mail Address: _____

Primary Specialty: _____ State License Number: _____

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

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

Physician/Group name must match IRS Tax ID Number

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

Group Name: _____

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

Company Name: _____ E Mail Address: _____

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

Telephone Number: ( ) _____ Contact Person: _____

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

Hospital Name: _____ Address: _____

Hospital Name: _____ Address: _____

Hospital Name: _____ Address: _____

Hospital Name: _____ Address: _____

Hospital Name: _____ Address: _____

Hospital Name: _____ Address: _____

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

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

_____ _____
SIGNATURE OF PHYSICIAN DATE

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

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

NON-COUNTY PHYSICIANS INDIGENT SERVICES PROGRAMS

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

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

The undersigned physician (hereinafter "Physician") certifies that claims submitted hereunder are for services provided by him/her to patients who do not have health insurance coverage for medical services and care, and who cannot afford to pay for services rendered, and for whom payment will not be made through any private coverage or by any program funded in whole or in part by the federal government. Programs covered by this single agreement include:

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

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

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

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

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

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

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

COUNTY OF LOS ANGELES ● DEPARTMENT OF HEALTH SERVICES

PHYSICIAN SERVICES FOR INDIGENTS PROGRAM – IMPACTED HOSPITAL PROGRAM

BILLING PROCEDURES

JULY 1, 2013 TO JUNE 30, 2016

I. INTRODUCTION

Pursuant to existing contracts with non-County hospitals for certain indigent services for Impacted Hospitals, a Physician Services for Indigents Program-Impacted Hospital Program ("PSIP-IHP") 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 to eligible indigent patients in a hospital participating in the Impacted Hospital Program (IHP). Professional physician services herein referred to are limited to services provided to patients 1) seen in the emergency room on an outpatient basis, or 2) seen in the emergency room and admitted, with payment for up to six (6) inpatient days, and one (1) follow-up outpatient visit.

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 herein and incorporated in the attached "Department of Health Services Physician Reimbursement Policies for Impacted Hospital.". 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.

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 immediately; 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 a County hospital.

II. PHYSICIAN ELIGIBILITY

A. Physician must complete a 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 4). Physician claims will not be accepted if said Agreement is not on file.

B. Physicians who provide services to patients 1) seen in the emergency room on an outpatient basis, or 2) seen in the emergency room and admitted, with payment for up to six (6) inpatient days, and one (1) follow-up outpatient visit to eligible patients in a Los Angeles County acute care hospital that has an Impacted Hospital Program Agreement with the County, may submit a claim hereunder.

C. Physicians and surgeons shall be eligible to receive payment for patient care services provided by, or in conjunction with, a properly credentialed nurse practitioner or physician's assistant for care rendered under the direct supervision of a physician and surgeon who is present in the facility where the patient is being treated and who is available for immediate consultation to the extent the physician is authorized to bill for such services and payment for such services will not be made to any hospital participants in the Impacted Hospital Program where such services were rendered. Payment shall be limited to those claims that are substantiated by a medical record and that have been reviewed and countersigned by the supervising physician and surgeon in accordance with regulations established for the supervision of nurse practitioners and physician assistants in California.

D. An emergency physician and surgeon or an emergency physician group with a gross billings arrangement with a hospital participating in the Impacted Hospital Program 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 at one of the Impacted Hospital Program hospitals.

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

Patients covered by this claiming process are only those who do not have health insurance coverage for 1) emergency room on an outpatient basis, or 2) who are seen in the emergency room and admitted, with payment for up to six (6) inpatient days, and one (1) follow-up outpatient visit, 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 by the federal government, including Full Scope Medi-Cal. Claims for patients with Limited Scope Medi-Cal will be restricted to services not covered by Medi-Cal.

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 with the hospital to determine if there is a responsible private or public third-party source of payment (e.g., application for coverage under Medi-Cal and/or Medicare, when appropriate), and

(b) patients for whom Physician has billed all possible payment sources, but has not received reimbursement for any portion of the amount billed; except for Limited Scope Medi-Cal patients who are no longer Medi-Cal eligible.

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.

If, after receiving payment from the County hereunder, Physician is reimbursed by a patient or a responsible third party, Physician shall immediately notify the County (see address below) in writing of the payment, and reimburse the County the amount received from the County.

MAKE REFUND CHECK PAYABLE TO:
County of Los Angeles/Department of Health Services
Refund checks should be accompanied by:
-- a copy of the Remittance Advice, and
-- a specific explanation for the refund, e.g., received payment for services from Medi-Cal, etc.

SUBMIT NOTIFICATION AND/OR REFUND TO:
County of Los Angeles/Department of Health Services
Fiscal Services – Impacted Hospital Program
313 North Figueroa Street, Room 505
Los Angeles, CA 90012

IV. CONDITIONS OF REIMBURSEMENT

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

V. CLAIM PERIOD

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

VI. REIMBURSEMENT

Payment of a valid claim hereunder will be limited to a maximum of 100% of Medicare allowable Area 18 fee schedule to include patient copayment amount of twenty percent (20%), not to exceed billed charges. The Impacted Hospital Program Fee Schedule utilizes the most current Physicians' Current Procedural Terminology (CPT-4) codes in conjunction with the Resource Based Relative Value Scale (RBRVS) unit values in affect on the date of admission.

VII. COMPLETION OF FORMS

A. Complete "Non-County Physicians Indigent Services Programs-Conditions of Participation Agreement" for the current fiscal year (sample attached). Submit one original signed Agreement to the contracted Claims Adjudicator:

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

B. Complete one CMS-1500 Form per patient including the following:

1. In Section 11, INSURED'S POLICY GROUP OR FECA NUMBER, and

2. The term "IMPACTED HOSPITAL" in Section 11c, INSURANCE PLAN NAME OR PROGRAM.

VIII. ELECTRONIC BILLING

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

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

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

X. CLAIM REJECTION AND APPEALS

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

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

XI. INFORMATION CONTACTS

For Status of Claims and Program/Policy Issues, call:
AIA Physician Hotline - (800) 303-5242

XII. COUNTY LIABILITY/PAYMENT/SUBROGATION

Payment of any claim under this claiming process is expressly contingent upon the availability of monies allocated therefor by the State and by the County of

Los Angeles Board of Supervisors. To the extent such monies are available for expenditure under the PSIP – IHP, 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.

Physician agrees to assign and subrogate all rights that s/he may have against any patient, his/her responsible relative, any third party tortfeasor for reimbursement as a result of care and services provided by Physician, and/or his/her staff, upon payment by County under the PSIP - IHP. At its sole discretion, County, and/or its contractor, may proceed independently against such parties for reimbursement to the extent permitted by law regardless of the amount the Physician has received under the PSIP - IHP. Physician agrees to cooperate with County and/or its contractors in the exercise of the rights assigned and subrogated to County under this provision.

XIII. GENERAL OBLIGATION OF PHYSICIANS SUBMITTING CLAIMS

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

A. Records/Audit Adjustment

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

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

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

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

billing records, and collections agency reports associated with the sampled claims.

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

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

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

B. Indemnification/Insurance

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

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

C. Non-discrimination

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

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

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

Covered Entity is subject to the Administrative Simplification requirements of the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191 ("HIPAA"), and regulations promulgated thereunder, including the Standards for Privacy of Individually Identifiable Health Information ("Privacy Regulations") and the Health Insurance Reform: Security Standards ("the Security Regulations") at 45 Code of Federal Regulations (C.F.R.) Parts 160 and 164 (together, the "Privacy and Security Regulations"). The Privacy and Security Regulations require Covered Entity to enter into a contract with Business Associate ("Business Associate Agreement") in order to mandate certain protections for the privacy and security of Protected Health Information, and those Regulations prohibit the disclosure to or use of Protected Health Information by Business Associate if such a contract is not in place.

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

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

COUNTY OF LOS ANGELES DEPARTMENT OF HEALTH SERVICES

PHYSICIAN SERVICES FOR INDIGENTS PROGRAM

PHYSICIAN REIMBURSEMENT POLICIES

JULY 1, 2013 TO JUNE 30, 2016

I. POLICY STATEMENT

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

II. GENERAL RULES

A. Impacted Hospital Fee Schedule: 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 pays at 100% of Medicare allowable Area 18 fee schedule to include patient copayment amount of twenty percent (20%), not to exceed billed charges. Reimbursement is also limited to the policy parameters contained herein.

B. Eligible Period: Reimbursement shall be limited to services provided to patients 1) seen in the emergency room on an outpatient basis, or 2) seen in the emergency room and admitted, with payment for up to six (6) inpatient days, and one (1) follow-up outpatient visit.

C. Exclusions:

1. Procedures which are not covered under Medicare are excluded from reimbursement.

2. Claims determined to be third party eligible, including Full Scope Medi-Cal and Medicare, will be denied. Claims for patients with Limited Scope Medi-Cal will be restricted to services not covered by Medi-Cal.

D. Assistant Surgeons: Reimbursement for assistant surgeons will be at a rate of 20% of the primary surgeon's fee (as per Medicare allowable fee schedule to include patient copayment amount of twenty percent [20%]).

E. Multiple Surgery Procedure Codes: Adjudication of claims involving multiple surgery procedure codes performed in an inpatient operating room requires submission of operative reports. The Procedure Codes shall be paid as follows: 100% for 1st procedure, 50% for the 2nd through the 4th procedures, and the remaining to be paid upon review of the operative reports.

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

G. Office Visits: Physicians will be reimbursed for one post-discharge Medicare eligible office visit.

III. INELIGIBLE CLAIMS

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

B. Unlisted Procedures: Procedures which are not paid by Medicare are excluded from reimbursement.

C. Non-physician Procedures: Procedures commonly not performed by a physician will be denied (e.g., venipuncture).

D. 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: Reimbursement for radiology codes will be limited to those appropriate to the differential diagnosis for the patient in the emergency department or inpatient setting.

B. EKGs: Reimbursement for EKG codes will be limited to those appropriate to the differential diagnosis for the patient in the emergency department or inpatient setting.

C. Pathology: Reimbursement for pathology codes will be limited to those codes eligible by Medicare.

D. Anesthesia: There are no exclusions as long as the procedure is billed per American Society of Anesthesiologists (ASA) codes.

V. ADDITIONAL EXCLUSIONS

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

VI. APPEALS

At the full discretion and authorization of the County, 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. Any determination by PRAC shall be advisory and for consideration by the County. Appeals shall include the CMS-1500, operative reports, if applicable, and supporting documents as needed. Appeals shall be mailed to the contracted Claims Adjudicator

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 PSIP Demographic Data Form, CMS-1500, operative reports, if applicable, and supporting documents as needed. Appeals shall be mailed to the contracted Claims Adjudicator:

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

COUNTY OF LOS ANGELES ! DEPARTMENT OF HEALTH SERVICES

NON-COUNTY PHYSICIANS

INSTRUCTIONS FOR SUBMISSION OF CLAIMS AND DATA COLLECTION

JULY 1, 2013 TO JUNE 30, 2016

. . . . . .

GENERAL INFORMATION

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

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

ALL CLAIMS should be submitted to American Insurance Administrators.

TRAUMA PHYSICIANS - SUBMIT CLAIMS:

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

ALL OTHER PHYSICIANS--SUBMIT CLAIMS TO:

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

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

COMPLETION OF PSIP DEMOGRAPHIC DATA FORM

PATIENT INFORMATION (Items #1-10)

1. TPS #

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

2. SOCIAL SECURITY #

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

3. PATIENT'S NAME

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

4. PLACE OF BIRTH

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

5. MOTHER'S MAIDEN NAME

   Enter Patient's mother's maiden name.

6. ETHNICITY

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

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

7. EMPLOYMENT TYPE

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

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

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

8. MONTHLY INCOME

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

9. FAMILY SIZE

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

! parent(s)

! children under 21 years of age living in the home. A child under 21 years of age who is in the military would be counted only if he/she gave his/her entire salary to the parent(s) for support of the family.

! children under 21 years of age living out of the home but supported by the parent(s), e.g., a child in college

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

10. SOURCE OF INCOME

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

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

PATIENT INFORMATION VERIFICATION (Items #26-27)

26. REASON(S)

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

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

27. SIGNATURE

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

PHYSICIAN SERVICES (Items #20-25)

20. PHYSICIAN FUND

Check appropriate box to indicate type of claim being submitted:

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

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

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

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

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

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

21. SERVICE SETTING

Check one of the following:

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

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

22. PHYSICIAN'S NAME AND STATE LICENSE NUMBER

Enter Physician's name and State license number.

23. PAYEE NAME, ADDRESS AND TAX ID NUMBER

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

24. DATE BILLED COUNTY

Enter date Physician billed the County.

CHARGES

Enter total amount of Physician charges.

25. CONTACT PERSON/TELEPHONE NO.

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

COMPLETION OF CMS-1500 FORM

The following CMS-1500 items must be completed:

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

Patient's Date of Birth and Sex

Patient's Address (city, state, zip)

Employment Information

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

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

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

Diagnoses (primary and two others)

Date of Service

Procedures (descriptions)

Patient's Account No.

Name and Address of Facility Where Services Were Rendered

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

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

COUNTY OF LOS ANGELES - DEPARTMENT OF HEALTH SERVICES

NON-COUNTY PHYSICIANS

PHYSICIAN SERVICES FOR INDIGENTS PROGRAM (PSIP) DEMOGRAPHIC DATA FORM

FOR EMS USE ONLY
TRAUMA YES ☐ NO ☐

PATIENT INFORMATION*

COMPLETE ENTIRE CLAIM AND SUBMIT WITH CMS-1500

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

3. PATIENT'S NAME _____
LAST FIRST MIDDLE INITIAL

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

4. PLACE OF BIRTH: _____
CITY STATE COUNTRY

5. MOTHER'S MAIDEN NAME: _____

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

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

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

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

PATIENT INFORMATION VERIFICATION

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

REASON(S): _____ (26)

SIGNATURE: _____ (27)

PHYSICIAN SERVICES

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

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

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

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

PAYEE ADDRESS: _____

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

FOR QUESTIONS REGARDING CLAIM:

25. CONTACT PERSON _____ TELEPHONE NO: ( ) _____

Rev. 06/01/13