COUNTY OF LOS ANGELES DEPARTMENT OF HEALTH SERVICES

PHYSICIAN SERVICES FOR INDIGENTS PROGRAM

BILLING PROCEDURES

JULY 1, 2016 TO JUNE 30, 2019

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;

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." 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, 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 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 possess a valid and current license to practice medicine in the State of California during the enrollment period when the emergency services are performed. Proof of licensure must be submitted with enrollment and updated whenever licensure renewed.

B. 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 5). Physician claims will not be accepted if said Agreement and Enrollment form is not on file.

C.. 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 124840, 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.

Notwithstanding paragraph II C 2 above, if it is necessary to transfer the patient to a second facility that provides for a higher level of care for the treatment of the emergency condition, reimbursement shall be available to the physician (or provider) who provided the care to the patient on the calendar day of transfer and on the immediately following two calendar days.

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

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

E. Physicians who provide medically necessary services for treatment of an emergency medical condition 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.

F. 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

Patients covered by this claiming process are only those who do not have health insurance coverage for emergency services and care, cannot afford to pay for services rendered, and for whom payment will not be made through any private coverage or by any program funded in whole or in part by the federal government, including Medi-Cal, but with the exception of claims submitted for reimbursement through Section 1011 of the Federal Medicare Prescription Drug, Improvement and Modernization Act of 2003.

During the time prior to submission of the bill to the County, 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 at least two (2) attempts to obtain reimbursement and has not received payment for any portion of the amount billed.

2. Physician has attempted to settle by offering to bill patients a reduced amount, i.e., a percentage of total charges.

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

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

Examples of when these County collection efforts might occur would include, but not necessarily be limited to, situations where there are third-party tortfeasors responsible for a patient's medical expenses. If, after receiving payment from the County hereunder, Physician is reimbursed by a patient or a responsible third party, Physician shall notify the County within 60 days of receipt of the payment (see address below) in writing of the payment, and reimburse the County the amount received from the County.

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

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

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

IV. CONDITIONS OF REIMBURSEMENT

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

V. CLAIM PERIOD

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

VI. REIMBURSEMENT

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

Reimbursement rates will be approved by the County for each fiscal year based on projected revenues and expenditures.

VII. COMPLETION OF FORMS

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

American Insurance Administrators (AIA)
P.O. BOX 17908
Los Angeles, CA 90017-0908

B. Complete one CMS-1500 Form per patient.

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

VIII. ELECTRONIC BILLING

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

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

American Insurance Administrators (AIA)
P.O. BOX 17908
Los Angeles, CA 90017-0908
ATTN: PSIP

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 February 15 of the following fiscal year.

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 resubmissions or appeals must be received by Claims Adjudicator within seven (7) months after the close of the fiscal year during which services were provided, no later than February 15 of the following fiscal year. All appeals shall be prepared and sent in accordance with the directions set forth in Exhibit "A".

XI. INFORMATION CONTACTS

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

XII. COUNTY LIABILITY/PAYMENT/SUBROGATION

Payment of any claim under this claiming process is expressly contingent upon the availability of monies allocated therefor by the State and by the County of Los Angeles Board of Supervisors (Board). 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.

Physician agrees to assign and subrogate all rights that s/he may have against any patient, his/her responsible relative, any third party tortfeasor or any other party for reimbursement as a result of care and services provided by Physician, and/or his/her staff, for which a claim has been submitted to County under the PSIP. At its sole discretion, County, and/or its contractor, may proceed independently against such parties for reimbursement to the extent permitted by law. The rights hereby assigned and subrogated to County under this provision include reimbursement for the full amount of any customary or actually billed charges of Physician, and his/her staff, for patient care and services regardless of the amount the Physician has received under the PSIP. 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 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 any 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 financial records, patient/insurance billing records, and collections agency reports associated with the sampled claims, medical records may also be requested.

Audited claims that do not comply with program requirements shall result in a refund to the County of the claim payment amount plus an assessment of twenty-five percent (25%) 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.