COUNTY OF LOS ANGELES DEPARTMENT OF HEALTH SERVICES

TRAUMA PHYSICIAN SERVICES PROGRAM

BILLING PROCEDURES

JULY 1, 2022 TO JUNE 30, 2025

I. INTRODUCTION

Pursuant to provisions of the State of California Welfare and Institutions Code, Sections 16950 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 trauma patients in hospitals designated by County contract as trauma hospitals.

This document defines the procedures which Physician must follow in seeking reimbursement for trauma services to indigent patients. Reimbursement is also limited to the policy parameters set forth herein and incorporated in the attached "Department of Health Services' Physician Reimbursement Policies." The County may revise such policies from time to time as deemed necessary or appropriate.

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 claims process is effective immediately; is only valid for trauma services to the extent that funds are available, and therefore, subject to County requirements.

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

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

This claims process may not be used by a physician if they are an employee of a County trauma 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 trauma services are provided. Proof of licensure must be submitted with enrollment and updated whenever licensure is renewed.

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

C. 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 County contract as a trauma hospital may submit a claim hereunder. (Physician employees of a County trauma hospital are not, however, eligible for reimbursement under this claiming process.)

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, reviewed and countersigned by the supervising physician and surgeon in accordance with regulations established for the supervision of nurse practitioners and physician assistants in California.

III. PATIENT ELIGIBILITY/BILLING EFFORTS

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

Before submitting 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 a 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) any of the following has occurred:

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

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

3. Physician has attempted to settle by offering to bill the patient a reduced amount, i.e. a percentage of total charges.

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 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:
Los Angeles County, Department of Health Services
Finance – Special Programs/Funds
1000 S Fremont Ave
Unit 8, Building A11, 2nd Floor South, Suite 1200
Alhambra, CA 91803

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.

VII. COMPLETION OF FORMS

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

American Insurance Administrators (AIA)
P.O. BOX 17908
Los Angeles, CA 90017-0908
E-Mail AIALAPSIP@MAPINC.COM

B. Complete one CMS-1500 Form per patient.

VIII. ELECTRONIC BILLING

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
FAX: (562) 692-8689 ATTN: TRAUMA CLAIMS
E-Mail: AIALAPSIP@MAPINC.COM

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 January 18 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 January 18 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:
American Insurance Administrators (AIA) Hotline - (800) 303-5242 or by
E-Mail: AIALAPSIP@MAPINC.COM

XII. COUNTY LIABILITY/PAYMENT/SUBROGATION

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

Physician agrees to assign and subrogate all rights that they may have against any patient, their responsible relative, any third party tortfeasor or any other party for reimbursement as a result of care and services provided by Physician, and/or their 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 total amount of any customary or actually billed charges of Physician, and his/her staff, for patient care and services regardless of the amount the Physician has received under the Trauma Services for Indigents Program. Physician agrees to cooperate with County and/or its contractors in the exercise of the rights assigned and subrogated to County under this provision.

XIII. GENERAL OBLIGATION OF PHYSICIANS SUBMITTING CLAIMS

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

A. Records/Audit Adjustment

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

2. Physician shall retain all such records 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 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 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 claims process, the Physician certifies that the services rendered by them, 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 claims process, the Physician further certifies that their 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 claims process, the Physician signifies that they have 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.