EMERGENCY MEDICAL SERVICES AGENCY
LOS ANGELES COUNTY

June 13, 2022

10100 Pioneer Boulevard, Suite 200
Santa Fe Springs, CA 90670

Tel: (562) 378-1500
Fax: (562) 941-5835

"To advance the health of our communities by ensuring quality emergency and disaster medical services."

TO: Eligible Physicians
Physician Services for Indigents Program

FROM: Richard Tadeo
Director

SUBJECT: **PHYSICIAN SERVICES FOR INDIGENTS PROGRAM - EMERGENCY SERVICES AND TRAUMA SERVICES**

The County of Los Angeles is opening enrollment for its Physician Services for Indigents Program (PSIP) for services provided to eligible patients. This is a three-year enrollment period that covers County Fiscal Years (FYs) 2022-23 through 2024-25 (July 1, 2022 through June 30, 2025).

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, 2022 through June 30, 2025.**

Each physician providing patient care under this program must complete an enrollment form and attach a copy of their current medical license. This form is for enrollment of a single physician, not a physician group. Any change in the physician information, (e.g., office address change, billing company change) will require completing and submitting of a Change Notice 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 rates for services provided from July 1, 2022 to June 30, 2023 will be the same rates used in FY 2020-21 and FY 2021-22. The non-trauma emergency (ER) claims will be paid at 13.5% and trauma claims will be paid at 100% of the Official County Fee Schedule (OCFS).

The reimbursement rate for the subsequent years in this enrollment period will be determined each year. Providers will be notified of the approved reimbursement rate once it is determined.

The following PSIP enrollment documents are attached to this letter:

1. PROGRAM ENROLLMENT PROVIDER FORM – JULY 1, 2022 TO JUNE 30, 2025
2. CONDITIONS OF PARTICIPATION AGREEMENT – JULY 1, 2022 TO JUNE 30, 2025
3. BILLING PROCEDURES
4. PHYSICIAN REIMBURSEMENT POLICY
5. INSTRUCTIONS FOR SUBMISSION OF CLAIMS AND DEMOGRAPHIC DATA FORM
6. INSTRUCTIONS FOR CHANGE NOTICE FORM

KEY INFORMATION POINTS IN THE ABOVE REFERENCED DOCUMENTS

- These reimbursement procedures and policies apply to services rendered to eligible patients for the period from July 1, 2022 through June 30, 2025.
- Physicians providing emergency services to eligible patients may be reimbursed for services provided on the calendar day on which emergency services are first provided, and on the immediately following two (2) calendar days.
- Each physician must complete a *Program Enrollment Provider Form* and *Conditions of Participation Agreement* before any claims will be processed. These documents may accompany the submission of the first claim.
- Enrollment forms and physician claims should be sent electronically or mailed directly to the County's Contract Claims Adjudicator
- Providers must submit a Change Notice Form and supporting documents to American Insurance Administrators (AIA) when any change in the physician information occurs

American Insurance Administrators (AIA)
P.O. Box 17908
Los Angeles, CA 90017-0908
(800) 303-5242
FAX #: (562) 692-8689
E-Mail: AIALAPSIP@MAPINC.COM

RT:jd

Attachments

c: Los Angeles County Medical Association
Hospital Association of Southern California

COUNTY OF LOS ANGELES • DEPARTMENT OF HEALTH SERVICES

PHYSICIAN REIMBURSEMENT PROGRAM

PROGRAM ENROLLMENT PROVIDER FORM
JULY 1, 2022 TO JUNE 30, 2025

Each Physician is required to complete an enrollment form

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

Address: _____ City: _____ Zip Code: _____

Contact Person: _____ NPI #: _____

Telephone No.: ( ) _____ E-mail Address: _____

Contact Person: _____ NPI #: _____

Telephone No.: ( ) _____ E-mail Address: _____

Primary Specialty: _____ State License Number: _____ **(attach a copy/proof of current licensure)**

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: _____

Contact Person: _____ Telephone Number: ( ) _____

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

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 (AIA)
P.O. BOX 17908
Los Angeles, CA 90017-0908
FAX #: (562) 692-8689 E-Mail: AIALAPSIP@MAPINC.COM

COUNTY OF LOS ANGELES DEPARTMENT OF HEALTH SERVICES

NON-COUNTY PHYSICIANS SERVICES FOR INDIGENTS PROGRAMS

JULY 1, 2022 TO JUNE 30, 2025
CONDITIONS OF PARTICIPATION AGREEMENT

SUBMIT TO: AMERICAN INSURANCE ADMINISTRATORS (AIA)
P.O. BOX 17908
Los Angeles, CA 90017-0908
E-mail: PSIP@MAPINC.COM

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.

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/, including, but not limited to, the proper refunding of monies to the County when patient or third-party health insurance 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. In the event the physician terminates the services of his/her billing company, it is the physicians responsibility to notify AIA and ensure all records are kept for future audit purposes. 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 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, or physician's billing company, agrees to cooperate with County and/or its contractors in the exercise of the rights assigned and subrogated to County under this provision. 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 and is ultimately responsible if his/her billing company does not provide information for an audit and for audit finding payments.

Physician certifies that information on claims submitted by him/her is true, accurate, and complete to the best of his/her knowledge. Physician certifies that he/she is licensed to practice medicine in the State of California and will maintain current licensure during the time period covered by this agreement (attach a copy of your current licensure).

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

COUNTY OF LOS ANGELES DEPARTMENT OF HEALTH SERVICES

TRAUMA PHYSICIAN SERVICES PROGRAM

BILLING PROCEDURES

JULY 1, 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.

COUNTY OF LOS ANGELES DEPARTMENT OF HEALTH SERVICES

PHYSICIAN REIMBURSEMENT PROGRAMS

PHYSICIAN REIMBURSEMENT POLICY

JULY 1, 2022 TO JUNE 30, 2025

I. POLICY STATEMENT

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

II. GENERAL RULES

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

B. Eligible Period: Reimbursement shall be for emergency medical services provided on the calendar day on which emergency services are first provided and on the immediately following two calendar days.

EXCEPTION: Trauma physicians providing trauma services at County contract trauma hospitals may bill for trauma physician services provided beyond this period.

C. Medi-Cal/Medicare Exclusions:

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

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

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

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

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

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

III. INELIGIBLE CLAIMS

A. 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.

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

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

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

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

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

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

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

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

G. Prior Dx Codes: Reimbursement will not be made for wound checks and suture removal.

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

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

V. ADDITIONAL EXCLUSIONS

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

VI. APPEALS

Appeals for claims rejected or denied may be submitted to the Physician Reimbursement Advisory Committee ("PRAC"), a committee of physicians selected by Hospital Council of Southern California and by the Los Angeles County Medical Association. Appeals shall include the 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 17908
Los Angeles, CA 90017-0908
ATTN: APPEALS UNIT
E-Mail: AIALAPSIP@MAPINC.COM
FAX #: (562) 692-8689

COUNTY OF LOS ANGELES DEPARTMENT OF HEALTH SERVICES

NON-COUNTY PHYSICIANS

INSTRUCTIONS FOR SUBMISSION OF CLAIMS AND DEMOGRAPHIC DATA FORM

JULY 1, 2022 TO JUNE 30, 2025

GENERAL INFORMATION

Physicians must submit an original copy of the **CMS-1500 Form** and the **Physician Services for Indigents Program (PSIP) Demographic Data Form** for each patient's care if they claim reimbursement under the County's PSIP. Information from both the PSIP Demographic Data Form and the CMS-1500 Form are used by the County to comply with state reporting mandates. **Originals of both the CMS-1500 Form and the PSIP Demographic Data Form must be completed for each patient. Photocopied documents/information will be rejected.**

PATIENT INFORMATION: Physicians, or their billing staff 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 EMERGENCY DEPARTMENT VISIT will not be accepted without completion of all data elements unless a reasonable justification is provided.**

ALL CLAIMS should be submitted to American Insurance Administrators (AIA)

TRAUMA CLAIMS - SUBMIT CLAIMS TO:

American Insurance Administrators (AIA)
P.O. BOX 17908
Los Angeles, CA 90017-0908
Attention: **TRAUMA CLAIMS**

E-Mail: AIALAPSIP@MAPINC.COM

AIA Physician Hotline - (800) 303-5242

COMPLETION OF PSIP DEMOGRAPHIC DATA FORM

PATIENT INFORMATION (Items 1-3)

1. TPS NUMBER

   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. PATIENT'S NAME

   Enter Patient's last name, first name, and middle initial.

PHYSICIAN SERVICES (Items 3-8)

3. PHYSICIAN FUND

   Check appropriate box to indicate type of claim being submitted:

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

   Antelope Valley Hospital
   California Hospital Medical Center
   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
   Pomona Valley 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 Emergency Medical Services Agency

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

4. SERVICE SETTING

Check one of the following:

(1) Inpatient
(2) Emergency Department

Also check the Anesthesia box if service was provided by an anesthesiologist

5. PHYSICIAN'S NAME AND STATE LICENSE NUMBER

Enter Physician's name and State license number.

6. PAYEE NAME, ADDRESS AND TAX ID NUMBER

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

7. DATE BILLED COUNTY

Enter date Physician billed the County.

CHARGES

Enter total amount of Physician charges.

8. CONTACT PERSON/TELEPHONE NO.

Enter name, telephone number and email address of two individuals 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

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
PHYSICIANS SERVICES FOR INDIGENTS PROGRAM (PSIP) DEMOGRAPHIC DATA FORM

PATIENT INFORMATION

COMPLETE ENTIRE FORM AND SUBMIT WITH CMS 1500

1. TPS# (trauma patients only) ☐

2. Patient Name _____
Last First Middle Initial

PHYSICIAN SERVICES

3. PHYSICIAN FUND

☐ (1) Trauma

☐ (2) Emergency Services

Check either box below

4. SERVICE SETTING

☐ Inpatient (patient was admitted to a bed)

OR

☐ Emergency Department only

Also check this box if service was provided by an anesthesiologist

☐ Anesthesia

5. Physician's Name _____ State License # _____

6. Payee Name _____ Payee Tax ID # _____

Payee Address _____

7. Date Billed County (e.g. 01/31/16) ☐☐☐
mm dd yy

Charges $ ☐

FOR QUESTIONS REGARDING THIS CLAIM

8. Contact Person _____ Telephone # _____

COUNTY OF LOS ANGELES DEPARTMENT OF HEALTH SERVICES

NON-COUNTY PHYSICIANS

INSTRUCTIONS FOR CHANGE NOTICE FORM

JULY 1, 2022 TO JUNE 30, 2025

GENERAL INFORMATION

Providers must submit a Change Notice Form and supporting documents to American Insurance Administrators (AIA) when any change in the physician information occurs (e.g., office address change, billing company change). Change Notice Forms and supporting documents can be faxed or e-mailed to:

PSIP Physician Enrollment Dept
Fax #: (562) 692-8689 Attention:
E-mail: AIALAPSIP@MAPINC.COM

INSTRUCTIONS FOR CHANGE NOTICE FORM

A. PROVIDER INFORMATION

ER PHYSICIAN

Check this box if enrolled as Physician and enter name of physician

ER GROUP

Check this box if enrolled as ER Group and enter name of group

EFFECTIVE DATE

Check this box and enter the effective date of change

PAYEE TAX ID

Check this box and enter the nine (9) digit federal tax ID number

B. CHANGE OF ADDRESS

If provider has changed their payee address (where the Remittance Advice (RA) and check are sent):

W-9 FORM

Check this box and attach a copy of the new W9 Form

PREVIOUS SUBMITTED PROGRAM ENROLLMENT FORM

Check this box and attach a copy of the previously submitted Program Enrollment Form

CONTACT PERSON

Enter contact person's name, telephone #, FAX # and E-mail address

PREVIOUS ADDRESS

Enter provider's previous address, city, state and zip code

NEW ADDRESS

Enter provider's new address, city, state and zip code

C. BILLING CHANGE:

If provider has changed their biller, or billing company and payee address will not be changing or provider has gone out of business

CHANGED BILLER

Check this box if provider changed biller

CHANGED BILLING COMPANY

Check this box if provider changed billing company

GONE OUT OF BUSINESS

Check this box if provider has gone out of business

NAME OF PREVIOUS BILLING COMPANY

Enter previous name of billing company and previous name of billing contact

PREVIOUS ADDRESS OF BILLING COMPANY

Enter previous address of billing company, city, state and zip code

NAME OF NEW BILLING COMPANY

Enter name of new billing company and name of new billing contact (if applicable)

NEW ADDRESS OF BILLING COMPANY

Enter new address of billing company, city, state and zip code

TELEPHONE #

Enter telephone #, FAX # and E-mail address of billing contact

D. CHANGE OF PROVIDER GROUP NAME OR CHANGE OF BILLER AND PAYEE ADDRESS

If provider has changed their group name or changed their biller and payee address (where the Remittance Advice (RA) and check are sent) WILL change, the provider must **re-enroll** in the program.

CHANGE OF PROVIDER GROUP NAME

Check this box If provider group name changed

INSTRUCTIONS FOR CHANGE NOTICE FORM

CHANGE OF BILLER AND PAYEE ADDRESS

Check this box if provider changed biller and payee address (where the Remittance Advice (RA) and check are sent)

PHYSICIAN'S LICENSURE

Check this box, and submit a copy of the physician's current license

PREVIOUS PROGRAM ENROLLMENT FORM

Check this box, and submit a copy of the previously submitted Program Enrollment Provider Form

W-9 FORM

Check this box and submit a copy of the new W9 Form

PROGRAM ENROLLMENT PROVIDER FORM

Check this box, complete and submit a new Program Enrollment Provider Form

CONDITIONS OF PARTICIPATION AGREEMENT

Check this box, complete and submit a new Conditions of Participation Form

E. UPDATED PHYSICIAN LICENSE:

Check this box and submit a copy of the new license.

COUNTY OF LOS ANGELES DEPARTMENT OF HEALTH SERVICES
PHYSICIAN SERVICES FOR INDIGENT PROGRAM (PSIP)
CHANGE NOTICE FORM

A. PROVIDER INFORMATION: Providers must submit a Change Notice Form and supporting documents to American Insurance Administrators (AIA) when any change in the physician information occurs (e.g., office address change, billing company change).

☐ **ER PHYSICIAN** _____ ☐ **ER GROUP** _____
Physician Name Physician Group Name

☐ EFFECTIVE DATE ____/____/____ ☐ PAYEE TAX ID _____

B. CHANGE OF ADDRESS: If provider has changed their payee address (where the Remittance Advice (RA) and check are sent:

Attach a copy of the: ☐ **W-9 Form** and ☐ **previously submitted Program Enrollment Provider Form**

Contact Person | Telephone # | FAX # | E-mail

Previous Address | City | State | Zip Code

New Address | City | State | Zip Code

C. BILLING CHANGE: If provider has changed their biller, or billing company and payee address will not be changing or provider has gone out of business:

☐**CHANGED BILLER** ☐**CHANGED BILLING COMPANY** ☐**GONE OUT OF BUSINESS**

Name of previous billing company | Name of previous billing contact

Previous address of billing Company | City | State | Zip Code

Name of new billing company (If applicable) | Name of new billing contact (If applicable)

New address of billing company | City | State | Zip Code

Telephone # | FAX # | E-mail

D. CHANGE OF PROVIDER GROUP NAME OR CHANGE OF BILLER AND PAYEE ADDRESS: If provider has changed their group name or changed their biller and payee address (where the Remittance Advice (RA) and check are sent) WILL change, the provider must re-enroll in the program.

☐ **CHANGE OF PROVIDER GROUP NAME** ☐ **CHANGE OF BILLER AND PAYEE ADDRESS**

Attach a copy of the following:
☐ physician's current license
☐ the previously submitted Program Enrollment Provider Form
☐ the new W9 Form
☐ Complete a new Program Enrollment Provider Form
☐ Complete a new Conditions of Participation Agreement Form

E. UPDATED PHYSICIAN LICENSE: Attach a copy of the ☐ **UPDATED PHYSICIAN LICENSE**

AMERICAN INSURANCE ADMINISTRATOR
PSIP Physician Enrollment Dept
FAX #: (562) 692-8689 **or**
E-MAIL: AIALAPSIP@MAPINC.COM