



CONTRA COSTA  
**HEALTH**

50 Douglas Dr. Ste. 310, Martinez, CA 94553 | Phone: 925.957.5400 | Fax: 925.957.5401  
cchealth.org

June 2, 2023

RE: Physician Uncompensated Care Relief Payment Program Rules

Dear Physician,

Contra Costa County is pleased to advise you that the FY 2023-2024 Physician Uncompensated Care Relief Payment Program rules covering services provided from July 1, 2023 through June 30, 2024 are now available. Copies of the rules may be accessed via the Contra Costa Health website at: [http://cchealth.org/provider\\_rules/](http://cchealth.org/provider_rules/).

Please note, as required by AB 1833 passed by the state legislature on September 9, 2002, Contra Costa County has adopted the Medicare Provider Fee Schedule as its uniform program standard fee schedule. **You are required to bill at the Medicare Provider Fee Schedule “Limiting Charge” rates rather than your usual and customary rates.**

Please review the rules carefully before submitting claims to prevent delays in processing or a potential denial of your claim. If you have any questions related to the rules, contact Christine Ang at (925) 957-5457 or by e-mail at [Christine.Ang@cchealth.org](mailto:Christine.Ang@cchealth.org).

Sincerely,

Patrick Godley  
Chief Operating Officer and Chief Financial Officer  
Contra Costa Health

PG/ca

**CONTRA COSTA COUNTY**  
**FY 2023-2024**  
**PHYSICIAN UNCOMPENSATED CARE RELIEF PAYMENT PROGRAM RULES**  
**FOR EMERGENCY MEDICAL SERVICES**  
**UNDER SB-12**

**I. OVERVIEW**

On July 1, 1988, the Contra Costa County Board of Supervisors established its SB-12 Emergency Medical Services Fund, pursuant to Chapter 1240, 1987 Statutes, to make relief payments to physicians for certain uncompensated emergency services. On January 1, 1989, the Board implemented the provisions of SB-612, which revised the percentage distribution of the SB-12 Emergency Medical Services Fund and increased the Traffic Court assessment fee from \$1 to \$2 on each \$10 of fines, penalties, and forfeitures for certain criminal offenses under SB-12. On January 16, 2007, the Board approved the additional penalty of \$2 for every \$10 upon various fines, penalties and forfeitures collected by courts for criminal offenses to be deposited into the EMS funds. 15% of this fund must be used to provide funding for all pediatric trauma centers throughout the County.

Authority for establishing this Emergency Medical Services Fund is found in Health and Safety Code Part I, Division 2.5, Section 1797.98. Pursuant to Welfare and Institution Code Section 16952, the County has established a Physician Services Account within this Fund.

The Board of Supervisors has designated Contra Costa Health to administer the Physician Uncompensated Care Relief Payment Program under the following uniform claim and payment procedures. Claims for relief payments on uncompensated emergency services will be paid from SB-12 funds on a monthly basis until they are exhausted. Claimants can only be paid up to the statutory maximum of fifty (50) percent of the Medicare Provider Fee Schedule. If the amount of the approved claims in any given month exceeds the available SB-12 funds, then the available funds will be prorated equitably among all claimants based on the proportion of approved claims to all approved claims for that service month.

**II. RELIEF PAYMENT LIMITATIONS**

- Emergency services provided by a physician in a general acute care hospital, which provides basic or comprehensive emergency services for emergency medical conditions as defined in Welfare and Institution Code, Section 16953 (under SB-12).

Relief payments for uncompensated emergency services are limited to emergency medical conditions as defined in Health and Safety Code Section 1317.1. Under SB-946, payment shall be made only for emergency services provided on the calendar day on which emergency medical services are first provided and on the following two calendar days; however, payment may not be made for services provided beyond a 48-hour period of continuous emergency services to the patient. Services rendered after a patient is stabilized are not covered.

Physician services provided by a physician employed by a county hospital are not eligible for relief payments. Physician services in a primary care clinic, which receives Tobacco Tax appropriations, are not eligible for payment.

### III. RELIEF PAYMENT CLAIM PROCESS

#### A. Eligibility

##### 1. Eligible Services

Emergency medical services must have been provided on an inpatient or outpatient basis, in a general acute care hospital which has a permit to provide basic or comprehensive emergency medical services, located in Contra Costa County.

##### 2. Eligibility Period

Services must have been rendered on or after July 1, 2023 through June 30, 2024 in Contra Costa County.

##### 3. Eligibility Patients

Payments under this claim procedure are limited to services provided to patients from whom no payment is received, and for whom payment will not be made through private coverage or by any program funded in whole or in part by the federal government. Payments are limited to services for which the physician, through reasonable billing and collection efforts, has not received any payment whatsoever from the patient, responsible relative, or a third-party payor. For purposes of this procedure, relief payments for uncompensated physician billings are limited to the following:

- a) Patients for whom the physician has inquired if there is a responsible private or public third-party source of payment.
- b) Patients for whom the physician has billed for payment, or has billed a responsible private or public third-party, and has made all reasonable collection efforts to obtain payment.
- c) Patients for whom the physician expects to receive payment for the services provided and has made reasonable efforts to collect payments.
- d) Physician bills which have been rejected for payment by the patient and any responsible third party. A bill is deemed rejected if either notification is received from the patient or third-party that no payment will be made for the

services or 90 days have passed from the date the physician initially billed the patient and/or responsible third-party payors without receipt of any payment.

- e) Patients for whom the physician has stopped any current and waives any future collection efforts to obtain payment from the patient.

#### 4. Eligible Charges

For purpose of claiming relief payments from the Physician Services Accounts, Physician shall claim only the Medicare Provider Fee Schedule "Limiting Charge," rate for a given Service provided.

### B. Claims

1. An Annual Certification Letter (see Attachment A) must be submitted with the first claim for services rendered in the current Fiscal Year. In addition, all claim packets consisting of one of the two claim methods (paper or electronic) described below and a *Physician Personal Data Form* (see Attachment B), must be sent to:

Contra Costa Health  
General Accounting Office/Physician Services Accounts  
50 Douglas Drive, Suite 310-C  
Martinez, CA 94553

2. Providers have two methods by which to submit claims for uncompensated care relief payments from the Physician Services Accounts:

- a) Paper Claim Form

Information can be hand-written or typed on a "Medically Indigent Data/Service Claim Form" (see Attachment C). This same claim form is used to claim all relief payment, regardless of service type or funding source.

- b) Claim Submission

Providers submitting more than 60 claims per month, or 500 Claims per year and along with the required Physician Personal Data form, may be transmitted via electronic mail (email). Following HIPAA guidelines, all electronic transmittals should be password protected.

3. Claims must be submitted as follows:

<u>Services Rendered In:</u>	<u>Claims Must Be Submitted on OR After:</u>	<u>But No later than and Postmarked By:</u>
July-2023	November 1, 2023	December 1, 2023
August-2023	December 1, 2023	January 1, 2024
September-2023	January 1, 2024	February 1, 2024
October-2023	February 1, 2024	March 1, 2024
November-2023	March 1,2024	April 1, 2024
December-2023	April 1, 2024	May 1, 2024
January-2024	May 1,2024	June 1, 2024
February-2024	June 1, 2024	July 1, 2024
March-2024	July 1, 2024	August 1, 2024
April-2024	August 1, 2024	September 1, 2024
May-2024	September 1, 2024	October 1, 2024
June-2024	October 1, 2024	November 1, 2024

However, claims for services for which a written denial from the patient and a third-party payor or Grantor (if any) is received may be submitted prior to the above submission dates (see Section A.3 (d) above). Such written denials must be attached to the claim.

CLAIMS SUBMITTED AFTER THE ABOVE DUE DATES WILL NOT BE ACCEPTED FOR PAYMENT CONSIDERATION.

4. Claim Form Data Element Definitions. *See Attachment D*

C. Assistance

For any questions or additional information regarding the claim process, please contact Christine Ang at (925) 957-5457 or by e-mail at [Christine.Ang@cchealth.org](mailto:Christine.Ang@cchealth.org).

IV. COUNTY LIABILITY / PAYMENT

A. Availability of Monies

1. Payment of any claim under this Program is expressly contingent upon the monies being received by the County under SB-12 and being available in the Physician Services Accounts for disbursement, less 10% of deposits for Administrative Expenses.
2. The county is not obligated to make payments to physicians for uncompensated patient care services except as expressly provided for in these Program Rules and Claim Procedure.

3. Eligible claims submitted in a timely manner will be paid by the County at the maximum allowable rate of 50% of the Medicare Provider Fee Schedule until the funds in the Physician Services Accounts are exhausted or on a prorated basis if total claims exceed available funds.

B. Payment

1. Payments shall not exceed 50% of the Medicare Provider Fee Schedule for any given service. If there are insufficient funds to allow that level of payment because of a disproportionately high number of claims for any given service month, then all funds available for that month shall be prorated equitably among claimants and approved claims for that month, as determined by the County at its sole discretion.
2. Claims presented to the County may be paid to the extent that funds are available, valid, proper, timely, and eligible. Payment will be made by county on a monthly basis. If available funds are not sufficient to pay all approved claims at the maximum 50% level for any given service month, available funds for that month will be prorated equitably among claimants based on the proportion of their approved claims to all approved claims in that month.

V. PHYSICIAN REFUNDS TO COUNTY

If after receiving payment from the County under this Uncompensated Care Relief Payment Program for uncompensated patient care services, the physician receives any payment from the patient or responsible party for the same services, the physician shall notify Contra Costa Health's General Accounting Office and County's payment on any subsequent claim by Physician shall be reduced accordingly by the amount of the payment received from the patient or responsible party, but not to exceed the amount paid by the County for this same service. In the event that there is no subsequent submission by the physician of a claim to the County for uncompensated services within one year of such notice, the physician shall refund to the County an amount equal to the amount collected from the patient or responsible party, but not to exceed the amount of County's payment for this same patient care services.

VI. PHYSICIAN RECORDS, AUDIT, AND PAYMENT ADJUSTMENT OBLIGATIONS

- A. The physician shall immediately prepare and thereafter maintain complete and accurate records sufficient to fully and accurately reflect the services and costs thereof, for which a claim has been made. Such records shall include, but are not limited to, patient name and identifying information, services provided, dates of service, charges, and payments received. Additionally, such records shall include proof of all billing efforts made and required by these rules.
- B. All such records shall be retained by the physician for a minimum of three years following the date of service.

- C. Such records shall be made available to representatives of the County's Auditor-Controller or Contra Costa Health, and to representatives of the State, upon request, at all reasonable times during the three-year period for the purpose of inspection, audit, and copying.
- D. If an audit conducted by County or State representatives of physician or hospital records, or both, relating to the services for which a claim was made and paid hereunder, finds that:
- 1) The records do not support the emergency medical nature of all, or a portion of the services provided, or
  - 2) No records exist to evidence the provision of all or a portion of the services, or
  - 3) The physician failed either to report or refund payment from other sources as required herein, or
  - 4) The records do not substantiate the required billing and collection efforts,
- the physician shall, upon receipt of County billing, therefore, remit forthwith to the County the difference between the claim amount paid by the County and the amount of the adjusted billing as determined by the audit.

## VII. INDEMNIFICATION AND CERTIFICATIONS

### A. Liability Insurance

- 1) By utilizing this claim procedure, the physician certifies that the services are rendered by he/her and for which claim is made, are covered under a program of professional liability insurance with a combined single limit coverage of not less than one million dollars per occurrence.
- 2) By utilizing this claim procedure, the physician further certifies that his/her worker's compensation coverage is in an amount and in compliance to meet all applicable requirements of the California Labor Code that specifically covers all persons providing services on behalf of the physician and all risks to such persons.
- 3) By utilizing this claim procedure, the physician further certifies that he/she maintains comprehensive auto liability insurance endorsed for all owned and non-owned vehicles used by his/her employees in connection with the professional services for which the claim is made, with a combined single limit coverage of at least \$100,000 per occurrence.

B. Non-Discrimination

By utilizing this claim procedure, the physician certifies that he/she has not discriminated in provision of services for which claim is made because of race, color, religion, national origin, ancestry, sex, age, or condition of physical or mental handicap, in accordance with all applicable requirements of Federal and State Law.

VIII. APPEAL PROCEDURES

Disputes regarding rejection of claims, amount of payment, or any other issue related to this claim procedure must be filed with Contra Costa Health's Chief Financial Officer within 30 days of payment or denial of the claim.

The County is not responsible for damages or costs which result from either the disputed adjusted billing or the filing of an appeal.

Settlement in favor of the physician cannot exceed 50% of the Medicare Provider Fee Schedule for the particular services actually rendered.

MAIL APPEALS TO:

Patrick Godley, Chief Financial Officer  
Contra Costa Health  
50 Douglas Drive, Suite 310A  
Martinez, CA 94553



**ATTACHMENT A**

CONTRA COSTA HEALTH  
FY 2023-2024 ANNUAL CERTIFICATION LETTER

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FOR RELIEF PAYMENT CLAIMS  
FOR PROVISION OF UNCOMPENSATED PHYSICIAN SERVICES  
COVERED BY CONTRA COSTA COUNTY PHYSICIAN SERVICES ACCOUNTS

To: Contra Costa Health  
General Accounting Office  
Attention: Physician Services Account  
50 Douglas Drive, Suite 310-C  
Martinez, CA 94553

I, the undersigned Physician, hereby submit this Claim, and future Claims, for relief payment(s) for provision of medically necessary services in Contra Costa County to an eligible patient for whom no payment of bills has been received, i.e., for uncompensated services, under the County's Physician Uncompensated Care Relief Payment program in one or more of the following categories:

EMERGENCY SERVICES I rendered in a hospital, which has a permit to provide basic or comprehensive emergency medical services.

I hereby acknowledge that I have received a copy of, have read, and agreed to comply with Contra Costa Health's FY 2023-2024 Physician Uncompensated Care Relief Payment Program Rules, effective July 1, 2023, the terms and conditions of which are incorporated herein by reference. I hereby certify that I have complied fully with the claiming conditions stated therein by submitting this Claim and that, in connection with this Claim, and all other physician billing requirements, duties and obligation (including but not limited to, the preparation, maintenance, and retention of medical service and financial records, and their availability for audit) have been and will be fulfilled by me.

I expressly acknowledge and understand that this Claim and any County payment therein is subject to and limited by those conditions defined in said Relief Payment Program Rules, including, among other requirements, the availability of monies in the Physician Services Accounts and payment audit adjustments.

I, the undersigned Physician, hereby certify under penalty of perjury that the claim information submitted herewith is true, accurate and complete to the best of my knowledge, and that this Annual Certification will apply to any and all claims that I submit for services rendered from July 1, 2023 through June 30, 2024.

By: \_\_\_\_\_, Dated: \_\_\_\_\_  
Typed or Printed Name of Physician

**ATTACHMENT B**

**PHYSICIAN PERSONAL DATA FORM**

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1. Applicant Name:

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2. Address (Actual Practice Location):

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3. City/State:

4. Zip:

5. Business Telephone:

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6. Primary Specialty of Physician:

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7. Professional License Number:

8. Expiration Date:

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9. Medi-Cal Provider:

10. Please indicate present billing arrangement or contract with hospital where services were provided:

STAFF PRIVILEGE

100% SALARIED BY FACILITY

RESIDENT

SALARIED FOR ADMIN ONLY

FELLOW

PARTIAL SALARY FOR PATIENT CARE

INTERN

OTHER (Explain at bottom of this form)

Please list hospital and address where services were provided:

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**AS A CONDITION TO CLAIMING REIMBURSEMENT FROM CONTRA COSTA COUNTY FOR EMERGENCY MEDICAL SERVICES, I CERTIFY THAT THE ABOVE INFORMATION IS TRUE, ACCURATE AND COMPLETE TO THE BEST OF MY KNOWLEDGE.**

\_\_\_\_\_  
Typed or Printed Name of Physician

\_\_\_\_\_  
Signature of Physician

\_\_\_\_\_  
Date

**ATTACHMENT C**

**CONTRA COSTA HEALTH  
MEDICALLY INDIGENT DATA FORM**

Patient's Last Name: \_\_\_\_\_

First Name: \_\_\_\_\_ M.I.: \_\_\_\_\_

Social Security Number: \_\_\_\_\_ Sex: \_\_\_\_\_

Race: \_\_\_\_\_ (1=White, 2=Black, 3=Hispanic, 4=Native American/Eskimo, Aleut, 5=Asian/Pacific Islander, 6=Other, 7=Unknown)

Date of Birth: \_\_\_\_\_ Patient's Zip Code: \_\_\_\_\_ Family Monthly Income: \_\_\_\_\_

Primary Wage Earner's Type of Employment: \_\_\_\_\_ (1=Executive, Professional, Technical, 2=Labor Production, 3=Service/Sales, 4=Agricultural, 5=Unemployed, 6=Unknown)

Number of Visits: \_\_\_\_\_

Primary Source of Income: \_\_\_\_\_ (1=None, 2=Employment, 3=Disability, 4=Retirement, 5=General Assistance, 6=Other, 7=Unknown)

Family Size: \_\_\_\_\_ Total Charges: \$ \_\_\_\_\_

County Expenditures: \$ \_\_\_\_\_ (County Use Only - Do Not Fill In)

Admit Date: \_\_\_\_\_ Discharge Date: \_\_\_\_\_

Principal Diagnosis Code: \_\_\_\_\_ Patient Class: \_\_\_\_\_ (I=Inpatient, O=Outpatient, E=E/R)

Service Setting: \_\_\_\_\_ (E=E/R, O=Hospital Outpatient Dept., C=Freestanding Clinic, M=M.D.'s Office) (Use only if Patient Class = 'O' or 'E')

E/R Type of Service: \_\_\_\_\_ Use only if Patient Class = 'E' (1=Non-emergency/release, 2=Emergency/Release or death, 3=Non-emergency/transfer, 4=Emergency/transfer, 5=Non-emergency/admit, 6=Emergency/admit)

Type of Service: \_\_\_\_\_ (Enter for Patient Class = 'O' only)  
(PRIM=Primary Care, AMSU=Ambulatory Surgery, DENT=Dental Care, SPEC=Specialty Care, OTHR=Other, RADI=Radiology)

Check if: Pediatrics \_\_\_\_\_ or Obstetrics \_\_\_\_\_

Provider Name: \_\_\_\_\_ Provider Number: \_\_\_\_\_

Provider Zip Code: \_\_\_\_\_

## ATTACHMENT D

### CLAIM FORM DATA ELEMENT DEFINITION

Most data elements are explained on the Medically Indigent Data/Service Claim Form. Some additional information follows:

- (A) Patient's Family Monthly Income is defined as wages and salaries (including commissions, tips and cash bonuses), net income from business or farm, pensions, dividends, interest, rents, welfare, unemployment or worker's 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. Indicate total dollar amount rounded to the nearest dollar.

THIS ITEM IS OPTIONAL

- (B) Primary Wage Earners Type of Employment (categories include):

- 1) Executive, administrative, managerial, professional, technical, and related support.
- 2) Production, inspection, repair, craft, handlers, helpers, laborers, and transportation.
- 3) Sales and services
- 4) Farming, forestry, and fishing
- 5) Unemployed
- 6) Unknown

THIS ITEM IS OPTIONAL

- (C) Primary Source of Income (indicates the largest single source of family income), coded as:

- 1) None
- 2) Earned through employment, including self-employment
- 3) Disability
- 4) Retirement
- 5) General or public assistance (welfare)
- 6) Other (e.g., V.A. benefits, interest dividends, rent, child support, alimony, etc.)
- 7) Unknown

THIS ITEM IS OPTIONAL

- (D) Admit Date should be the date of service for outpatient and E/R encounters. An encounter is defined as a single visit and includes all services rendered during that visit. A patient receiving ancillary services only such as lab work, X-rays, or physical therapy should not be counted as a separate encounter but linked to the original date of encounter. Subsequent visits to a provider, whether or not they are related to the initial illness episode, will be considered

as a separate encounter. ALL INPATIENTS MUST HAVE BOTH THE ADMIT AND DISCHARGE DATES. THE NUMBER OF VISITS IS REQUIRED FOR OUTPATIENTS.

- (E) Discharge Date should be the date on which the patient was discharged from the hospital, transferred from the facility or died.

THIS ITEM IS REQUIRED FOR INPATIENTS

- (F) Principal Diagnosis Code is required for all inpatients (use appropriate ICD-9 diagnosis codes) but is required for outpatient and E/R service settings only when the patient has AIDS or an AIDS-related condition (the appropriate ICD-9 code would be 042).

THIS FIELD MUST BE COMPLETED FOR INPATIENTS

- (G) E/R type of Service: Emergency is defined in W&I code, Section 16593 as a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, which in the absence of immediate medical attention could reasonably be expected to result in any of the following:

- 1) Placing the patient's health in serious jeopardy
- 2) Serious impairment to bodily functions
- 3) Serious dysfunction to any bodily organ or part

Services rendered in an emergency room are classified as:

- 1) Non-emergency, resulting in being released from the hospital
- 2) Emergency, resulting in release or death
- 3) Non-emergency, resulting in a transfer to another hospital
- 4) Emergency, resulting in hospital admission
- 5) Non-emergency, resulting in the hospital admission
- 6) Emergency, resulting in a hospital admission

- (H) Types of service Definitions of the less obvious terms as follows:

▪ **Primary Care** is defined here as by physicians in the following specialties:

General Practice  
Family Practice  
Internal Medicine  
Obstetrics  
Gynecology  
Pediatrics

▪ **Specialty Care** is defined as care given by physicians who are not among the specialties listed above under Primary Care. Note that Ambulatory Surgery is excluded from this category in order to account separately for these services.

▪ **Ambulatory Surgery** is defined in the same way that Medi-Cal defines it. Consult the Medi-Cal Policy Statement (Number 82-15) for a listing of procedures comprising ambulatory surgery.

(I) The Provider Number field should be completed as follows:

- 1) Outpatient providers should use the last six digits of their employer's identification number.
- 2) Physicians should use the last six digits of their license number.

(J) The following patient data elements are REQUIRED FOR ALL PATIENTS:

- 1) Patient Name
- 2) Unique patient identifier (Social Security Number)
- 3) Sex
- 4) Race
- 5) Date of Birth
- 6) Zip Code of residence
- 7) Number of visits (Outpatient)
- 8) Total Medicare Provider Fee Schedule "Limiting Charge" rate amount to the patient or patient's payor source
- 9) Date of Service (Admit Date)
- 10) Discharge date (Inpatient)
- 11) Diagnosis (all inpatient, and outpatient only if AIDS/AIDS- related complex)
- 12) Type of service
- 13) Service setting
- 14) Emergency/Non -Emergency status and disposition of ER patients
- 15) Indication if service rendered was Pediatrics or Obstetrics
- 16) Provider Name
- 17) Provider Number
- 18) Provider Zip Code

(K) The following patient data elements are optional:

- 1) Family size
- 2) Family gross monthly income
- 3) Family principal income source
- 4) Type of employment