



ALAMEDA COUNTY HEALTH CARE SERVICES AGENCY
Public Health Department – Administrative Services
Finance-Contracts and Grant Claiming

**MADDY EMERGENCY MEDICAL SERVICES FUND (SB 12) PHYSICIAN
REIMBURSEMENT GUIDELINES FOR UNCOMPENSATED EMERGENCY
MEDICAL SERVICES**
EFFECTIVE JANUARY 1, 2007

Authority: California Health and Safety Code
Chapter 2.5 – Emergency Medical Services Fund
Added by SB 12 (CH 1240) 1987
Amended by SB 612 (CH 945) 1988; SB 2098 (CH 1171) 1990;
SB 946 (CH 1169) 1991.
Amended by SB 1683 (CH 1143) 1994
Amended by SB 623 (CH 679) 1999
Amended by SB 941 (CH 671) 2005

Source of Fund: Penalty Assessments made for this purpose as provided in Section
1465 of the Penal Code.

Fund Disbursement: Fund shall be utilized to reimburse physicians and surgeons and hospitals for patients who do not make payment for emergency medical services and for other emergency medical services purposes as determined by the County.

Disbursement from the Fund is governed by existing legislation and is allocated as follows:

- 58% - Physician Reimbursements
- 25% - Hospital(s) providing disproportionate trauma and emergency medical care
- 17% - County discretionary emergency medical services

10% of each portion of the fund is allocated for administrative costs.

Note: Per SB2132, Tobacco tax revenues are used to reimburse physicians and surgeons following the same guidelines applicable to the SB 12 program. Alameda County's Measure A will also augment these funds.

Administration of Fund:

The Alameda County Public Health Department Administrative Services Division will administer the SB 12 Fund.

- Process claims monthly.
- Use the CPT procedural terminology reference for payment of claims.
- Reconcile and maintain monthly Fund balance.
- Determine Fund amount available for physician reimbursement – monthly.

- Prepare and submit required reports as required by legislation.
- Establish equitable mechanism for resolving disputes relating to claims reimbursements.
- Provide enrollment information to physicians interested in participating in the program.
- Screen claims for Medi-Cal eligibility.
- Screen claims for CMSP eligibility for Oakcare Medical Group claims.
- Maintain roster of Program participants.
- Publish Program Guidelines.
- Compile semiannually a listing of physicians and hospitals that have received reimbursement from the Fund and the amount of the reimbursement received. This listing shall be made available, upon request, to any member of the public.
- Establish mechanism for appropriate medical review of claims in cooperation with Alameda Contra Costa Medical Association (ACCMA).
- Prepare and submit annual State Fund Report. These reports shall be made available, upon request, to any member of the public.

Reimbursement Guidelines

Payment of claims under the SB 12 Program is limited to the availability of monies in the SB 12 Fund. Valid claims submitted to the Public Health Department, by the last day of the month will be processed for payment by the 15th day of the following month.

All payments from the fund shall be limited to claims for care rendered by physicians or surgeons to patients who are initially medically screened, evaluated, treated, or stabilized in a:

- Basic or comprehensive emergency department of a licensed general acute care hospital in Alameda County;
- Site that was approved by a county prior to 1/1/90 as a paramedic receiving station for the treatment of emergency patients; a standby emergency department that was in existence on 1/1/89 in a hospital specified in section 124840;

Payments shall be made only for emergency medical services provided on the calendar day on which emergency medical services are first provided or the immediately following two calendar days. If it is necessary to transfer a patient to a second facility that provides for a higher level of care for the treatment of the emergency condition, reimbursement shall be available for services provided on the calendar day of transfer and on the immediately following two calendar days.

Reimbursement for losses incurred by any physician or surgeon shall be limited to services provided to a patient who does not have health insurance coverage for emergency services and care, cannot afford to pay for those services, 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, and where all the following conditions have been met:

1. The physician/surgeon has inquired if there is a responsible third party source of payment.
2. The physician/surgeon has billed the responsible third party, if any, or patient for payment of services.

3. Either of the following:

- The physician/surgeon has received actual notification from the patient or responsible third party that no payment will be made for the services rendered by the physician and surgeon.
- A period of not less than three months has passed from the date the physician/surgeon billed the patient or responsible third party, during which time the physician/surgeon made reasonable efforts to obtain reimbursement and has not received reimbursement for any portion of the amount billed.

4. The physician/surgeon has stopped any current, and waives any future, collection efforts to obtain reimbursement from the patient, upon receipt of moneys from the fund.

Claims are to be submitted on an HCFA-1500 claim form. The Public Health Department has the ability to process claims electronically. The guidelines and procedure for electronic claiming can be found elsewhere in documents entitled “EDI TRADING PARTNER GUIDELINES” and “EDI COMPANION GUIDE,” which are available online or from the SB 12 Manager in the Public Health Department.

Each physician or surgeon shall submit yearly a certification of compliance with the Alameda County Public Health Department established claiming process. This certification will be mailed to the provider several weeks prior to January 1st of each year.

Paper claims shall be sent to:

Alameda County Public Health Department, Administrative Services
SB 12 Program – Claims Processing
Attention: SB 12 Manager
1000 Broadway, Suite 500
Oakland, Ca 94607

Time limit for submission of valid claims shall be eighteen 18 months following the date of service. ***For all denied claims resubmission, the original claims and copies of EOB must be included.***

Maximum reimbursement shall be the lesser of 50% of the Medicare Limiting Charge fee schedule or the physician’s billed charges, utilizing current procedural terminology (CPT) for procedure codes, for the first eleven months of the fiscal year. The full amount of the maximum allowable fee reimbursement will be paid if there are sufficient funds available to pay for all claims submitted during the month. If the fund is not sufficient to pay all claims, the percentage of the total claimed amount which the fund constitutes will be the level at which the claims will be paid; i.e. if the fund balance is only 50% of the maximum allowable amount of billed claims, all claims will be paid at the rate of 50% of the approved reimbursement level. However, reimbursement from the Maddy (SB 12) Fund will be augmented by reimbursement from Tobacco tax revenues, per SB 2132, and the County’s Measure A funds.

In the event that the fund exceeds the amount paid in any given month, the amount of excess will be carried forward and made available for reimbursement in the following month. All funds remaining at the end of the fiscal year in excess of the 15% reserve held and rolled over to the next year

pursuant to this law shall be distributed proportionally, based on the dollar amount of claims submitted and paid to all physicians and surgeons who submitted qualifying claims during that year.

Reimbursement to Fund

If, after payment from the Fund, the patient or responsible party reimburses a physician, physician shall reimburse the Fund in an amount equal to the amount collected from the patient or responsible payor but not more than the amount of reimbursement previously received from the Fund.

Records/Audit Adjustments

Physician/surgeon shall keep and maintain records sufficient to fully and accurately reflect the services and costs related to the claim. Such records shall include, but are not limited to:

- Patient name and address
- Other patient identifying information, as needed
- Services provided
- Date(s) of service(s) and charges
- Proof of billing and collection efforts as necessary

Physician shall retain all records for a minimum of three years following the date the service was provided. Such records shall be made available to representatives of the Public Health Department or to authorized representatives of the State, upon request, during normal working hours during such three-year period for the purpose of inspection, audit and copying.

If County or State representatives conduct an audit of physician or hospital records related to services for which a claim was made and paid and find that:

- Records do not support the emergency medical nature for all or part of the services provided,
- No records exist to evidence the provision of all or a portion of the services,
- Physician failed to report or remit payments from other sources as required,

then Physician shall remit to the fund the difference between the claim amount paid by the Fund and the amount of the adjusted billing as determined by the audit.

Physicians and surgeons found to submit requests for reimbursement that are inaccurate or unsupported by records may be excluded from submitting future requests for reimbursement.