Health Services
LOS ANGELES COUNTY

Los Angeles County
Board of Supervisors

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January 13, 2009

The Honorable Board of Supervisors
County of Los Angeles
383 Kenneth Hahn Hall of Administration
500 West Temple Street
Los Angeles, California 90012

Dear Supervisors:

APPROVAL OF REVISED REIMBURSEMENT RATES AND PHYSICIAN SERVICES FOR INDIGENTS PROGRAM (PSIP) AGREEMENTS (ALL SUPERVISORIAL DISTRICTS) (3 VOTES)

John F. Schunhoff, Ph.D.
Interim Director

Robert G. Splawn, M.D.
Interim Chief Medical Officer

313 N. Figueroa Street, Suite 912
Los Angeles, CA 90012

Tel: 213-240-8101
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www.dhs.lacounty.gov

To improve health through leadership, service and education

SUBJECT

Request approval of revised rates and agreements to reimburse non-County physicians for providing emergency services to indigents.

IT IS RECOMMENDED THAT YOUR BOARD:

1. Approve and delegate authority to the Interim Director of Health Services, or his designee, to reduce the initial reimbursement rate for PSIP to 27 percent of the Official County Fee Schedule (OCFS) for Fiscal Year (FY) 2008-09 and offer revised emergency physician services agreements for FY 2008-09, to eligible non-County physicians providing emergency services at non-County emergency hospitals.

2. Delegate authority to the Interim Director of Health Services, or his designee, to offer new emergency physician services agreements to eligible providers, upon review and approval by County Counsel and the Chief Executive Officer and notification to your Board.

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3. Delegate authority to the Interim Director of Health Services, or his designee, on a year to year basis, up to a maximum of five years to further reduce the reimbursement rate in future fiscal years, up to a minimum of 25 percent; authorize supplemental payments if significant funding remains in the PSIP at fiscal year end; and offer revised emergency physician services agreements, upon review and approval by County Counsel and the Chief Executive Officer and notification to your Board.

PURPOSE/JUSTIFICATION OF RECOMMENDED ACTIONS

Approval of the recommended actions will allow the Interim Director to reduce the initial reimbursement rate for non-County physician emergency services claims from 29 percent to 27 percent of the OCFS effective with July 1, 2008 service dates, as stated in Exhibit I, and offer revised emergency physician services agreements, substantially similar to Exhibit II, which incorporate the OCFS and the revised emergency services reimbursement rate for FY 2008-09.

In addition, delegated authority will allow the Interim Director to offer new emergency physician services agreements to eligible providers within the parameters set forth herein; reduce the initial reimbursement rate to no less than 25 percent of OCFS in future fiscal years, as necessary, to ensure all claims submitted by non-County physicians providing emergency services at non-County emergency hospitals are at least partially reimbursed, and to subsequently increase the rate, not to exceed 34 percent of OCFS, if significant funding remains at fiscal year end in the PSIP.

Implementation of Strategic Plan Goals

The recommended actions support Goal 1, Service Excellence of the County's Strategic Plan by enhancing the County's ability to prepare hospitals and supporting health care systems to deliver coordinated and effective care to victims of terrorism and other public health emergencies.

FISCAL IMPACT/FINANCING

Funding for PSIP emergency services claims, to the extent available, will be provided 100 percent by Emergency Medical Services Appropriation (EMSA), SB 612 (Maddy)/SB 1773, and "Measure B" Trauma Property Assessment funds (for St. Francis Medical Center emergency services claims.) Funding for these services is included in the Department's FY 2008-09 Final Budget.

FACTS AND PROVISIONS/LEGAL REQUIREMENTS

SB 612 (Maddy)

In 1987, the California Legislature enacted Chapter 1240, Statutes of 1987, allowing counties to establish an Emergency Medical Services Maddy fund to compensate physicians and medical facilities for non-trauma emergency services provided to indigent patients. The funds (SB 612 funds) are derived from additional penalties assessed on fines and bail forfeitures that the courts collect for certain criminal offenses and motor vehicle violations. The formula for fund distribution, including the percentage for the PSIP, is specified in the California Health and Safety Code, Section 1797.98a. Early in the program, the annual deposits to the County's PSIP exceeded reimbursements, creating a surplus maintained in a growing reserve fund. This reserve fund totaled $12.0 million at the end of FY 2000-01. Factors that have reduced this reserve fund are the increase in the number of physicians participating in the reimbursement program; an increase in reimbursement rates prompted by problems maintaining physician call panels for hospital emergency departments; legislation placing a limit on the amount of reserve funds allowed; and the elimination of the California Healthcare for Indigent Patients (CHIP) allocation in FY 2008-09.

Proposition 99

In October 1989, the Governor signed into law AB 75 which contained provisions for the distribution of Proposition 99 Tobacco Tax revenues. AB 75 established the CHIP, a program that appropriates Statewide funding for hospitals, physicians and other health services for indigent persons. These funds are allocated to counties based primarily on each county's share of the financial burden of providing health services to those who are unable to pay. AB 75 dictates the portion of these funds that must be allocated to the County's PSIP. Over the years, Proposition 99 funding for the PSIP steadily decreased, with no funding provided in FY 2002-03 or FY 2003-04. The decline in this revenue source greatly contributed to the increasing use of the SB 612 reserve fund to maintain the OCFS. There has been some restoration of Proposition 99 funding through FY 2007-08, but the State has eliminated this funding as of FY 2008-09.

EMSA

Starting in FY 2001-02, to partially restore diminishing Proposition 99 funds available for the PSIP, the State's budget has included an EMSA effective FY 2001-02, specifically for reimbursement of non-trauma emergency physician services provided to indigent patients.

Measure B

On February 22, 2005, your Board approved the Trauma Center Service Augmentation Agreement with St. Francis Medical Center with provisions and funding for increased emergency room and trauma patient volume. "Measure B" funds were appropriated to backfill a shortfall of other State and local funding needed to maintain the current reimbursement rates for the PSIP at St. Francis Medical Center and the Countywide non-County Physician Trauma Services for Indigents Program for all private trauma centers. The Department of Health Services (DHS) will seek Board approval for any further allocation of Measure B funds.

SB 1773

On March 6, 2007, your Board approved a resolution to implement the provisions of SB 1773. SB 1773 allowed the Board to levy an additional penalty in the amount of $2 for every $10, upon fines, penalties, and forfeitures collected for certain criminal offenses for support of emergency medical services. This legislation was to be repealed on January 1, 2009, however, AB 2702 was passed on September 25, 2008 to extend this provision until January 1, 2014. On September 28, 2008, AB 3076 was passed to revise SB 1773's language to allow the county to collect these penalties on traffic school fees as well, resulting in an additional $2.1 million allocated for non-County physicians through September 2008.

Revised Reimbursement Rates

On February 7, 2006, your Board approved DHS' request to reduce the initial reimbursement rate for non-County physician services claims, from 34 percent to 29 percent effective July 1, 2005. Significant funding remained at year end for FY 2005-06 and a supplemental payment was made which represented an increase from 29 percent to 34 percent.

The reimbursement rate must be reduced to 27 percent to ensure there are sufficient funds available to provide an equivalent reimbursement rate for all FY 2008-09 claims due to static revenue streams and rising claim volumes. Continuing with the reimbursement rate of 29 percent could result in non-payment of some claims. Should a significant amount of funding remain after payment of all claims a supplemental payment may be made, not to exceed 34 percent, as specified in Exhibit II. The reimbursement rate for trauma services claims will remain at 50 percent of the OCFS.

Additional funds received from SB 1773 have augmented the funding available to pay for medically indigent emergency services. However, despite this additional revenue,

the County is projecting insufficient funding to reimburse all claims at the 29 percent rate because the number of physicians participating in the program has increased by 14 percent from FY 2005-06 to FY 2007-08 and claims have increased a projected 27 percent from FY 2005-06 to FY 2007-08.

In the event the State legislature should revise existing law governing administration of PSIP funding sources, it may be necessary to accordingly revise the County's PSIP policies and procedures.

The Department established the Physician Reimbursement Advisory Committee (PRAC) pursuant to provisions of the State of California Welfare and Institutions Code ("WIC"), Sections 16950, et seq., and Health and Safety Code ("HSC"), Section 1797.98a, et seq., as an advisory committee to DHS to make recommendations on physician reimbursement policies and procedures and to review appeals of adjudicated or denied claims. The membership is comprised primarily of physicians representing such organizations as the Los Angeles County Medical Association, the California Chapter of the American College of Emergency Physicians, and the County's Trauma Hospital Advisory Committee. Other members represent the Hospital Council of Southern California, billing agencies, and DHS. The PRAC supports this recommendation.

County Counsel has reviewed and approved Exhibit II as to use and form.

CONTRACTING PROCESS

Any non-County physician providing emergency services to indigent patients at non-County hospitals is eligible to participate in the PSIP by completing the FY 2008-09 Conditions of Participation Agreement and the Enrollment Form.

IMPACT ON CURRENT SERVICES (OR PROJECTS)

Approval of the revised reimbursement rate will ensure payment for all submitted claims for FY 2008-09.

CONCLUSION

When approved, DHS requires three signed copies of the Board's action.

Respectfully submitted,

John F. Schunhoff, Ph.D.
Interim Director

JFS:ja

Attachments (2)

c: Chief Executive Officer
County Counsel
Executive Officer, Board of Supervisors

PSIP BL

EXHIBIT I

COUNTY OF LOS ANGELES
PHYSICIAN SERVICES FOR INDIGENTS PROGRAM

EFFECTIVE JULY 1, 2008

OFFICIAL COUNTY FEE SCHEDULE:

Official County Fee Schedule (OCFS) for Physicians: Utilizes the most current Physicians' Current Procedural Terminology (CPT-4) codes in conjunction with the Resource Bases 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. The conversion factor for anesthesiology is $48.77.

REIMBURSEMENT RATES:

Reimbursement of a valid claim for:

Trauma: The initial payment rate in effect on the date of service shall be 50% of the OCFS, not to exceed 100% of physician charges.

Other Emergency Services: The initial payment rate in effect on the date of service shall be 27% of the OCFS, not to exceed 100% of physician charges. In order to ensure that all claims are paid at an equivalent rate, this percentage may be increased to no more than 34% of the OCFS and not to exceed 100% of physician charges, based on actual program revenue and the actual volume of claims paid.

COUNTY OF LOS ANGELES • DEPARTMENT OF HEALTH SERVICES

NON-COUNTY PHYSICIANS INDIGENT SERVICES PROGRAMS

FISCAL YEAR 2008/09
CONDITIONS OF PARTICIPATION AGREEMENT

SUBMIT TO: AMERICAN INSURANCE ADMINISTRATORS (AIA)
P.O. BOX 2340
BASSETT, CALIFORNIA 91746-0340

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.
Impacted Hospital Program -- Emergency services and/or inpatient services provided for up to six inpatient days at a Los Angeles County designated Impacted Hospitals (associated with closure of MLK-Harbor Hospital).
Physicians Services for Indigents Program-MetroCare -- Inpatient services for patients transferred from a County-operated or Impacted Hospitals (see above) to St. Vincent Medical 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, for fiscal year 2008/09, 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/her, including, but not limited to, the proper refunding of monies to the County when patient or third-party 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. 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 tortfeasor or any other party for reimbursement as a result of care and services provided by Physician, and/or his/her staff, for which a claim has been submitted to County under 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 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.

Physician certifies that information on claims submitted by him/her is true, accurate, and complete to the best of his/her knowledge.

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

PHYSICIAN SERVICES FOR INDIGENTS PROGRAM

BILLING PROCEDURES

● ● ● Revised for Fiscal Year 2008/09 ● ● ●

I. INTRODUCTION

Pursuant to provisions of the State of California Welfare and Institutions code ("WIC"), sections 16950, et seq., and Health and Safety Code ("HSC"), sections 1797.98a, et seq., a Physician Services for Indigents Program ("PSIP") has been established by the County of Los Angeles ("County") to provide reimbursement to private physicians ("Physician") for certain professional services that have been rendered in Los Angeles County to eligible indigent patients. Professional physician services herein referred to are limited to emergency services as defined in WIC, section 16953; obstetric services as defined in WIC, section 16905.5; and pediatric services as defined in WIC, section 16907.5.

Professional physician services which can be reimbursed under this claiming process are additionally restricted as prescribed by the County, with such restrictions subject to revision from time to time. Current County physician reimbursement restrictions are set forth in "Department of Health Services Physician Reimbursement Policies, Revised for Fiscal Year 2008/09", attached as Exhibit "A" hereto and incorporated herein by reference. The County has discretion to revise such policies from time to time as deemed necessary or appropriate and if approved by the Board of Supervisors.

In no event may this claiming process be used by Physician if his/her services are included in whole or in part in hospital or physician services claimed by a hospital or by Physician under a separate formal contract with County. Nor may this claiming process be used if Physician has previously billed County for his/her emergency, obstetric, or pediatric services under any other claiming process established by County.

This document defines the procedures which must be followed by Physician in seeking reimbursement under this Program. Submission of a claim by Physician under these procedures establishes (1) a contractual relationship between the County and Physician covering the services provided and (2) signifies Physician's acceptance of all terms and conditions herein.

These claiming procedures are effective July 1, 2008; are only valid for covered services to the extent that monies are available therefor; and are subject to revisions as required by State laws and regulations and County requirements. This claiming process may not be used by a physician if he or she is an employee of a County hospital.

II. PHYSICIAN ELIGIBILITY

A. Physician must complete a current fiscal year Physician Services for Indigents Program "Conditions of Participation Agreement" and "Program Enrollment Provider Form" and provide them to the County's Emergency Medical Services ("EMS") Agency in care of the contracted Claims Adjudicator (see address on page 5). Physician claims will not be accepted if said Agreement is not on file with the EMS Agency.

B. Physicians who provide emergency services to eligible patients in a Los Angeles County (1) basic or comprehensive emergency department of a licensed general acute care hospital, (2) standby emergency department that was in existence on January 1, 1989 in a small and rural hospital as defined in HSC, section 124840, or (3) site approved by the County prior to January 1, 1990, as a paramedic receiving station for the treatment of patients with emergency medical conditions, may submit claims hereunder, if all the following conditions are met:

1. Emergency services are provided in person, on site, and in an eligible service setting.

2. Emergency services are provided on the calendar day on which emergency services are first provided, and on the immediately following two calendar days.

Notwithstanding paragraph II B 2 above, if it is necessary to transfer the patient to a second facility that provides for a higher level of care for the treatment of the emergency condition, reimbursement shall be available for services provided to the facility to which the patient was transferred on the calendar day of transfer and on the immediately following two calendar days.

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

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

D. Physicians who provide medically necessary obstetric or pediatric services to an eligible patient in a hospital, emergency department, or private office located in Los Angeles County, other than a hospital, emergency department or office owned

or operated by the County, may submit a claim hereunder. However, no physician may submit a claim for services provided in a primary care clinic which receives funding under provisions of Chapter 1331, Statutes of 1989.

E. An emergency physician and surgeon or an emergency physician group with a gross billings arrangement with a hospital located in Los Angeles County shall be entitled to receive reimbursement for services provided in that hospital, if all of the following conditions are met:

1. The services are provided in a basic or comprehensive general acute care hospital emergency department.

2. The physician and surgeon is not an employee of the hospital.

3. All provisions of Section III of these Billing Procedures are satisfied, except that payment to the emergency physician and surgeon, or an emergency physician group, by a hospital pursuant to a gross billings arrangement shall not be interpreted to mean that payment for a patient is made by a responsible third party.

4. Reimbursement is sought by the hospital or the hospital's designee, as the billing and collection agent for the emergency physician and surgeon or an emergency physician group.

For the purposes of this section, a "gross billings arrangement" is an arrangement whereby a hospital serves as the billing and collection agent for the emergency physician and surgeon, or an emergency physician group, and pays a percentage of the emergency physician and surgeon's or group's billings for all patients.

III. PATIENT ELIGIBILITY/BILLING EFFORTS

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

During the time prior to submission of the bill to the County, Physician must have made reasonable efforts to obtain reimbursement and not received payment for any portion of the amount billed. For purposes of this claiming process, reimbursement for unpaid physician billings shall be limited to the following:

(a) patients for whom Physician has conducted reasonable inquiry to determine if there is a responsible private or public third-party source of payment; and

(b) patients for whom Physician has billed all possible payment sources, but has not received reimbursement for any portion of the amount billed; and

(c) either of the following has occurred:

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

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

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

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

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

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

SUBMIT NOTIFICATION AND/OR REFUND TO:
County of Los Angeles/Department of Health Services
Special Funds Unit
313 North Figueroa Street, Room 531
Los Angeles, CA 90012
ATTN: CHIP Program

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.

IV. CLAIM PERIOD

Claims may only be submitted for eligible services provided on/or after July 1, 2008 and through June 30, 2009. All claims for services provided during the fiscal year 2008/09 (July 1 through June 30) must be received by County's Claim Adjudicator no later than October 31, 2009. Claims received after this fiscal year deadline has passed will not be paid. Unless sooner terminated, canceled, or amended, this claim process shall expire on October 31, 2009.

V. REIMBURSEMENT

Reimbursement of a valid claim hereunder will be limited to a maximum of 34% 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.

Based on available funding, the payment rate for FY 2008/09 is 27% of the OCFS. In order to ensure that all claims are paid at the same rate, this percentage figure may be increased to not more that 34%, based on the anticipated program revenue and the actual volume of claims.

VI. COMPLETION OF FORMS

A. Complete "Fiscal Year 2008/09 Conditions of Participation Agreement" for the current fiscal year Physician Services for Indigents Program (sample attached as Exhibit "D"). Submit one original signed Agreement to the contracted Claims Adjudicator:

American Insurance Administrators (AIA)
P.O. BOX 2340
Bassett, CA 91746-0340

B. Complete one HFCA-1500 Form per patient.

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

VII. ELECTRONIC BILLING

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

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

American Insurance Administrators (AIA)
P.O. BOX 2340
Bassett, CA 91746-0340
ATTN: PSIP

X. CLAIM REJECTION AND APPEALS

A. Revised claims previously rejected for incomplete information must be received by the contracted Claims Adjudicator within 20 calendar days from the date of the rejection letter.

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 appeals shall be prepared and sent in accordance with the directions set forth in Exhibit "A".

XI. INFORMATION CONTACTS

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

XII. COUNTY LIABILITY/PAYMENT/SUBROGATION

Payment of any claim under this claiming process is expressly contingent upon the availability of monies allocated therefor by the State and by the County of Los Angeles Board of Supervisors. To the extent such monies are available for expenditure under the Physician Services for Indigents Program, and until such available monies are exhausted, valid claims may be paid. Valid claims will be paid in the order of receipt;

that is, if a complete and correct claim is received by County, it will have priority over claims subsequently received.

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

XIII. GENERAL OBLIGATION OF PHYSICIANS SUBMITTING CLAIMS

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

A. Records/Audit Adjustment

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

2. All such records shall be retained by Physician at a location in Los Angeles County for a minimum of three (3) years following the last date of the Physician services to the patient.

3. Such records shall be made available during normal County working hours to representatives of the County and/or State, upon request, at all reasonable times during such three year period for the purposes of inspection, audit, and copying. Photocopying capability must be made available to County representatives during 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 medical and financial records, patient/insurance billing records, and collections agency reports associated with the sampled claims.

Audited claims that do not comply with program requirements shall result in a refund to the County.

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, upon receipt of County audit refunding therefor, 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.

County also reserves the right to exclude Physician from reimbursement of future claims for any failure to satisfy conditions of this claiming process.

B. Indemnification/Insurance

By utilizing this claiming process, the Physician certifies that the services rendered by him/her, and for which claim is made, are covered under a program of professional liability insurance with a combined single-limit of not less than one million dollars ($1,000,000) per occurrence and three million dollars ($3,000,000) aggregate.

By utilizing this claiming process, the Physician further certifies that his/her workers' compensation coverage is in an amount and form to meet all applicable requirements of the California Labor Code, and that it specifically covers all persons providing services on behalf of the Physician and all risks to such persons.

C. Non-discrimination

In utilizing this claiming process, the Physician signifies that he/she has not discriminated in the provision of services for which claim is made because of race, color, religion, national origin, ancestry, sex, age, physical or mental disability, or medical condition and has complied in this respect with all applicable non-discrimination requirements of Federal and State law.

XIV. COMPLIANCE WITH HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996

The parties acknowledge the existence of the Health Insurance Portability and Accountability Act of 1996 and its implementing regulations ('HIPAA'). Contractor understands and agrees that, as a provider of medical treatment services, it is a 'covered entity' under HIPAA and, as such, has obligations with respect to the confidentiality, privacy, and security of patients' medical information, and must take certain steps to preserve the confidentiality of this information, both internally and externally, including the training of its staff and the establishment of proper procedures for the release of such information, and the use of appropriate consents and authorizations specified under HIPAA.

The parties acknowledge their separate and independent obligations with respect to HIPAA, and that such obligations relate to transactions and code sets, privacy, and security. Contractor understands and agrees that it is separately and independently responsible for compliance with HIPAA in all these areas and that County has not undertaken any responsibility for compliance on Contractor's behalf. Contractor has not relied, and will not in any way rely, on County for legal advice or other representations with respect to Contractor's obligations under HIPAA, but will independently seek its own counsel and take the necessary measures to comply with the law and its implementing regulations.

CONTRACTOR AND COUNTY UNDERSTAND AND AGREE THAT EACH ISINDEPENDENTLY RESPONSIBLE FOR HIPAA COMPLIANCE AND AGREE TO TAKE ALL NECESSARY AND REASONABLE ACTIONS TO COMPLY WITH THE REQUIREMENTS OF THE HIPAA LAW AND IMPLEMENTING REGULATIONS RELATED TO TRANSACTIONS AND CODE SET, PRIVACY, AND SECURITY. EACH PARTY FURTHER AGREES TO INDEMNIFY AND HOLD HARMLESS THE OTHER PARTY (INCLUDING THEIR OFFICERS, EMPLOYEES, AND AGENTS), FOR ITS FAILURE TO COMPLY WITH HIPAA.