On Your Behalf …
Legislative and Practice Affairs Division

Billing Service Contracts

By Phillip Goldberg, Esq., CSA Legal Counsel

Anesthesiologists are often attentive to the terms and conditions of their contracts with third-party payers. Contracts between an anesthesia group and a hospital, surgery center or other facility where services are provided, usually are the subject of intense scrutiny and negotiation before they are signed by the parties. However, there is an important contract that virtually every anesthesiologist or anesthesia group has which rarely gets any time or attention: the billing service contract. The lack of concern or interest in billing service contracts is remarkable considering that the cost of billing services is typically the single greatest practice expense for an anesthesiologist or anesthesia group. This article will describe what should and should not be in the billing service contract.

Who is Working for Whom?

Most billing service contracts are written backwards. That is, they are written so it appears that the anesthesiologist or anesthesia group (hereafter "Client") is working for the billing service (hereafter "Billing Company"), as opposed to the other way around. The billing service contract is first and foremost a service contract, with the Billing Company acting as the service provider and the Client as the service recipient. As such, the terms should focus on the services the Billing Company provides to the Client and not on the Client's obligations to the Billing Company. Indeed, the Client's only obligations should be working cooperatively with the Billing Company in submitting complete and accurate information for bill preparation and paying the Billing Company's fees.

The Scope of Services

Although the scope of services from one billing service contract to another can vary significantly, and many companies provide what might be more appropriately described as consulting or practice management services, it is essential that the basic billing services to be performed by the Billing Company be set forth clearly in the contract. The services might be described as "appropriate bill preparation, transmittal to responsible payers, follow-up as commercially reasonable, and posting and deposit as collections are received." Beyond these

basic billing services, the Client often contracts for credentialing services, even if it does not get more comprehensive (and costly) consulting or management services. In all events, the contract should clarify that it extends to billings to patients and third-party payers defined broadly to include any and all payers. In deference to the Billing Company, details on the complete and accurate information to be provided by the Client should be included as well. The hours during which the Billing Company will be in operation should be stated clearly in the contract. This is important not only for communications from the Client but also for the convenience of patients and third-party payers.

Beyond generating and following up bills, and posting and depositing collections, the Billing Company should also generate reports. These reports give the Client an understanding of what type of job the Billing Company is doing, keep the Client informed about cash flow, and help identify problems with specific payers. At a minimum, the reports specified in the billing service contract should include aged accounts receivables, which may be sorted by payer, service location, or other classification. The Billing Company should provide reports on a periodic basis as stated in the contract, but they should also be available as "reasonably requested by Client," for which an additional fee may apply.

An essential element of every billing service contract is a statement of the standard applicable to the Billing Company's services, with references to both expertise and care. For instance, the Billing Company might be required to utilize "staff qualified to furnish the billing services with appropriate levels of education, training, and experience." The volume and depth of services should be that "reasonably required and customary for anesthesia practices." Additionally, the billing services should be provided with "due care, prudence, and judgment" and "in compliance with all applicable third-party payer rules and regulations, both commercial and governmental."

Ownership and Custody of Records

The Billing Company should take responsibility for maintaining custody of all original source documentation and any and all bills, reports, or other information relating to the services it provides and the bills it generates, as well as its communications with patients and third-party payers. More important, the billing service contract should specify that all such records "are and will remain the sole property of Client." Disputes over ownership of records can be particularly frustrating. If you have not clearly established your ownership of records, along with the Billing Company's obligation to maintain them and make them available to you on request, you may run into problems when the relationship with your Billing Company terminates. Although the Client does

not want to take custody of what may be a substantial volume of records, this is far preferable to being denied access to those records. For similar reasons, the billing service contract should cover what protocols the Billing Company employs to preserve and back up electronic data.

Related to ownership and control of records is the Client's right to audit those records. The billing service contract should specify that the Client has the right to review and audit, through an agent hired by Client if desired, "all billing and collection information in the custody or control of the Billing Company." It is reasonable to require the Client to give advance notice to the Billing Company, not disrupt the Billing Company's operations, and conduct the audit during regular business hours. The Billing Company, which may have legitimate concerns if the audit is conducted by a competing service, may reasonably request that a direct competitor not conduct the audit and may require a confidentiality agreement from any auditor. Conversely, the Billing Company should offer its full cooperation with any audit. The right of audit is essential to ensure that the Billing Company has performed up to the standard set forth in the billing service contract.

Collections and Payment of the Billing Company Fee

The billing service contract should not include a provision regarding the Billing Company paying the Client because the collections are (or certainly should be) the exclusive property of the Client. The accounts receivables before they are collected, the checks by which payments are made, and the account into which the checks are deposited are the property of the Client and the billing service contract should make this perfectly clear. The contract should also indicate that funds received by the Billing Company should be deposited immediately into the Client's account. Clarifying the Client's ownership of accounts receivables, checks, and deposits would be a good idea in all events, but it also helps to ensure compliance with Medicare rules on billing services, which have been a focus of the Office of Inspector General of the Department of Health and Human Services. To ensure compliance with the Medicare rules, a "lockbox" account into which payments are deposited and over which the Client has exclusive access should be established.

A careful review of the Medicare rules on billing service arrangements could lead to the conclusion that the commonplace "percentage of collections" fee arrangements violate the rules. However, the Centers for Medicare and Medicaid Services indicates (rather cryptically) that percentages of collections fee arrangements are acceptable when a lockbox account is used. The Billing Company should not have access to the lockbox account and should receive payment of its fee from the Client as opposed to taking it out of collections.

Although fees based upon a percentage of collections are not the only means for calculating compensation, they are by far the most common. The billing service contract should specify the percentage of collections (and not billings) on which the fee is calculated as well as specifying the time for payment. Ideally, the Billing Company should generate an invoice because it has information available on collections. Monthly calculation and payment of the fee is common, but a more or less frequent basis is allowed.

Confidentiality and HIPAA Compliance

The billing service contract should make clear that **all** information provided by the Client to the Billing Company is to be considered and maintained as confidential and not just that information which constitutes "protected health information" or "PHI" under HIPAA. The billing service contract should include standard "business associate" language to ensure the Client is compliant with its own obligations under HIPAA. The Billing Company should be well aware of these requirements and familiar with the obligations imposed under the law on its use of PHI.

Term and Termination

Whether or not there is any express term to the billing service contract, it should allow either party to terminate the relationship without cause on a reasonable period of notice. The right to terminate without cause may not be exercisable during the first year when the Billing Company is getting "up to speed" and has a legitimate interest in recovering start-up costs. When the Client is terminating the relationship, it probably wants the notice period to be as short as possible. Thirty to 60 days might be appropriate. Conversely, if it is the Billing Company terminating the relationship, the Client may want a longer period of notice to find a substitute. In this case, 90 to 120 days might be more appropriate. There is no legal requirement that the notice period for termination by the Client be the same as the notice period for termination by the Billing Company, but this is the most common arrangement. The billing service contract should specify a much shorter period for termination **for cause.** Typically, a notice of default giving rise to termination would be given and the defaulting party afforded an opportunity to cure within a relatively brief period of time. If the Client's obligations are properly limited to reasonable cooperation and paying the fee, it is much more likely that the Client will be the one terminating for cause. Accordingly, the cure period might be as brief as five to 10 days.

The billing service contract should specify the causes for termination which, most important, includes breach of the contract. The breach by the Billing

Company will almost always involve some degree of subjectivity. Including a standard for the services rendered helps to establish a basis for termination for cause by the Client when the services have not been as expected. The failure to meet that standard will constitute a breach, giving the Client the right to provide notice of the default, which will result in termination if not cured in short order.

Except in the case where the billing service contract is terminated because of a breach by the Client, the Client should have the option of having the Billing Company commit to continue to provide services after the effective date of termination. That is, the Client may require the Billing Company to "runoff" the receivables for dates of service prior to the date of termination. On the other hand, the Client should be free to collect information on its accounts receivables from the old Billing Company and transfer it to the new Billing Company, if it does not exercise its option to have the old Billing Company run off the receivables. In most circumstances, the Client will want the runoff performed by the old Billing Company since payers would have received instructions to deliver payment (or at least payment information) to the old Billing Company's address. It is important to clarify the special compensation arrangements, if any, that apply during the runoff period and on termination.

No matter how or when the relationship with the Billing Company is terminated, the Client should expect that some collections will be lost when moving from one company to another. In order to help diminish this inevitable loss, the billing service contract should specify that the old company shall cooperate in good faith with any new company that the Client identifies. This cooperation should include, at a minimum, the "transmittal of accounts receivable and other information to the replacement service in such form and format as the replacement service may reasonably request." This language is intended to facilitate an electronic transfer of data to avoid the need for the new service to input information manually into its system given the time and inaccuracy associated with this exercise. It does not mean the old company has to incur unreasonable expenses to transfer data electronically from one system to the other, but it certainly means that the old Billing Company cannot refuse to make an electronic transfer that only involves a few keystrokes.

Conclusion

I suspect most anesthesiologists comparing their current billing service contract with the comments in this article will find little connection between the two. Obviously, some of the provisions I suggest are more important than others. Similarly, some of the provisions will be easier for a Billing Company to accept than others. Nevertheless, there are good reasons for each of the provisions

suggested. Ultimately, what may be more important than the terms of your billing service contract is the strength and quality of your relationship with the Billing Company. However, when that relationship deteriorates, you will want billing service contract terms that protect your interests.

Whither Health Reform?

By William E. Barnaby, Sr. & Jr., CSA Legislative Counsel and Legislative Advocate

For the entire "Year of Health Care Reform," as 2007 was designated by Governor Schwarzenegger, the public was told that something close to universal healthcare in California was near.

There was going to be health insurance for at least 5 million of the state's uninsured residents. Health insurers would have to cover everybody who applied, with no exclusions for pre-existing conditions. Health insurers would have to devote 85 cents of every premium dollar to patient care. An additional $3 billion or $4 billion would be added to the Medi-Cal program to bring provider payment rates up to respectable levels.

"Shared responsibility" by everyone, be they individual citizen/taxpayers, health caregivers, health insurers, or employers, all would give up something for the common good. Nirvana was just around the corner. At least that is what the Governor's public relations operation relentlessly promoted. An impressive series of national political writers, topnotch business CEOs, think tank leaders, and assorted power brokers praised the brilliant "plan." It was remindful of a movie script.

The end came suddenly in late January of 2009. Poof, it was all gone. Why? The state's deteriorating economy no doubt was part of the reason. But there were signals from the outset, about which some of us repeatedly advised, that chances for this all-encompassing complete overhaul of healthcare in California were problematic.

No Authors for the Governor

Not a single legislator volunteered to author the Governor's proposal. Normally there would be a rush of lawmakers to take the lead on such a highly visible,

widely supported, and desirable goal. Especially when led by the popular celebrity/hero, Arnold Schwarzenegger. If anybody could pull off such a massive undertaking, the larger-than-life "Terminator" could. And it offered opportunities for free and positive media coverage that most politicians would die for.

The lack of a bill, or legislative package, spelling out the specifics was explained early on by the Governor's spokespersons as being under negotiation with multiple "stakeholders." To a certain extent that was true. And, at the same time, it belied a weakness of the effort. For months, separate negotiations were conducted by Schwarzenegger staffers with physicians, hospitals, ancillary health practitioners, health insurers, employers, labor unions, senior citizen groups, consumer advocates, and legislative leaders. Key gubernatorial aides worked on the project day and night, weekends, and holidays. The effort reeked of good intentions and long hours. When one of the many moving parts was resolved by negotiating with one group, it often unraveled other distinct parts and interests. A cohesive, coherent package never came together.

Democratic Assembly Speaker Fabian Nunez and Senate President Pro Tem Don Perata each authored comprehensive bills that provided a focus for legislative drafting. In the late summer, the two merged efforts into a single bill, AB 8, with Nunez as lead author. Meanwhile, Republican legislators made it clear not a single one would help produce the two-thirds vote needed for any new taxes or fees to finance expanded health coverage.

The Health Tax Two-Step

To get around the GOP barrier to the new money needed for health reform, the Governor and the Democratic leadership hit upon a novel approach. First, a health coverage plan, absent funding, would be legislated into statute. It would be so enticing that voters would implement it by approving new taxes in a ballot initiative. And, for good measure, it would prove that incumbent legislators were doing such a fine job that voters would change term limits and grant them more time in office. A trifecta had been hatched! Coincidentally, the same political consulting team that engineered a term-limit change onto our very own February 2008 presidential primary ballot as Proposition 93 was tapped by Nunez to ready a health tax proposal for the upcoming November election.

On the last day of the regular 2007 session, AB 8 was passed and sent to the Governor. On the deadline day to sign or veto bills, the Governor vetoed AB 8. He had already called a special session on health reform, so the stage was set to negotiate his preferences into an AB 8-type vehicle.

The special session drifted along until November when a form of the Schwarzenegger proposal finally emerged in legislation as ABX1 1 (Nunez). With the days of the "Year of Health Care Reform" dwindling down to a precious few, the special session was summoned into action. The 239-page, repeatedly amended ABX1 1 was hastily approved by two committees and the Assembly floor on party line votes. Time for testimony before the Assembly Health Committee was limited, and hard questions were few. CMA spoke for medicine. Some misgivings were raised but the emphasis was on CMA's long support for expanding health coverage to more Californians.

Perhaps the most cogent message came from Donna Gerber of the California Nurses Association (CNA). "Nobody really knows what's in this bill," she aptly observed. CNA had its own ax to grind, to be sure, but the contents of the bill were so complex and confused—from months of private negotiations, public pronouncements, and compromises done, undone and redone—that understanding its complicated terms was not possible particularly on short notice.

The Christmas holidays were near and pressure was on the Senate to move the bill quickly to the Governor so the implementing ballot initiative could meet petition signature-gathering deadlines. Reality then intervened.

Show Us the Money

A $14 billion budget deficit was coming into focus due to lagging tax receipts from a sagging state economy. Senate President Pro Tem Perata called time out. No further action, he ordered, pending a detailed fiscal review of the plan by trusted nonpartisan Legislative Analyst Elizabeth Hill. Coupled with a section-by-section analysis promised by Senate Health Committee Chair Sheila Kuehl, the end game was signaled.

An 11-hour Senate Health Committee hearing dissected the bill as members expressed increasing uneasiness. Serious questions were raised about cost projections and how various parts would work. Good things don't matter "if there isn't the money to pay for them," Kuehl said. "It just didn't hang together," she noted afterwards. Following a weekend to mull a decision, a roll call netted support from just one of the Committee's 11 members. Health reform was stillborn after gestating for 13 months.

Lessons Learned

Bringing about wholesale changes to an exceedingly complex healthcare delivery system is a huge challenge to say the least. Advancing major reform by stringing together goals, wishes, and dreams without openly constructing workable mechanisms for interactions between government agencies, private entities,

and caregivers is a fatal flaw. And it raises the hopes and expectations of an already skeptical public.

Public posturing through speeches and media events is no substitute for attention to detail and substantive action. Happy endings can be written into movie scripts easily. Not so when it comes to extending basic healthcare to 5 million people in a program proposed to be the third largest in California state government—behind only K-12 education and Medi-Cal. In this regard, the Governor apparently felt his proposal had been fully vetted through his town hall meetings around the state, rather than through detailed legislative scrutiny.

Public policy may be more influenced by public relations "spin" today than ever before, but a lack of substance cannot be hidden forever. A "box of smoke" was how proposals once were known around the Capitol when high-blown rhetoric displaced substantive details. The criticism of Health Care Reform might be too harsh in light of the good intentions and hard work that went into the effort. Yet it just might be a guide for the future.

Interestingly, the demise of the Governor's health plan faded rapidly from view. Other than a mild complaint by Nunez that the bill wasn't fully understood by the Senate Health Committee and the Governor's wondering what Senator Perata's "real" reasons were, the year-long effort quickly became old news and disappeared into history. Medicine took the high road and fared well. By allowing CMA to speak for the house of medicine, it was not possible to play off different specialties against each other. By remaining in support of expanded health coverage but quietly raising objections to a number of troubling parts of the proposal, medicine preserved its credibility and its overriding concern for patient care.

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