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BILLING COMPANY CONTRACTS: ACCOUNTABILITY AND PITFALLS

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Billing Company Contracts: Accountability and Pitfalls

The principal is responsible for the acts of the agent.

When Medicare was enacted in 1966, there likely was never any expectation that submitting claims to get paid would become as complex for physicians as it is today, nor that electronic systems would become the heart of the claims payment process. Once there was money to be had by submitting Medicare claims though, the failure to collect upon initial requests or repeated requests for payment led physicians (and others) to engage the services of collection agencies, which had traditionally been paid for their level of effort by earning a percentage of what they actually succeeded in collecting. Their contingent fees made perfect sense – no effort, no result; more effort, bigger result. Saving physician practices from the tedium of having to follow up on claims, those physician practices who engaged them were quite comfortable with letting these companies have a piece of the reimbursement pie, which the practice otherwise likely wouldn't collect at all.

By fourteen years after Medicare's enactment, with multiple reimbursement and fraud and abuse measures having been adopted by Congress, the need to contain the market in Medicare's "commercial paper" was apparent. Collection agencies were hounding patients. Payments were being made in the names of entities far removed from the actual delivery of care. Even after some reassignment rules had been first published, they were circumvented with powers of attorney, which the government then further restricted.[1] More on that later.

As the fraud and abuse enforcement environment has intensified, with False Claims Act challenges from the government and whistleblowers, the significance of billing company agreements has itself increased. Not only can these relationships expose the physician practice to government prosecution, both civil and criminal, they can also lose a practice money with little recourse for the billing company's failures. The companies themselves have their own liabilities, and should have requisite protections in their agreements governing these essential relationships. Additionally, when Congress in October, 2003 under the Administrative Simplification Compliance Act,[2] mandated that doctors submit electronic claims in order to be paid, it created significant new opportunities for medical billers, software developers, clearinghouses and ancillary services related to the claims process. Yet, this critical aspect of physician practice has been largely ignored in the legal literature. These contracts need significant attention from both sides of the table; and, as this article will demonstrate, the large majority of them should be substantially beefed up. Still further, as discussed more fully here, a wide range of other entities engaged in broader transactions, (e.g., private equity, health systems purchasing and running physician practices and more) conduct these activities for the physician practices to which they relate; and the billing relationships have had almost no attention in the context of those transactions– at all.

[1] 45 Fed Reg 26700 (April 21, 1980)

[2] PL 107-105

The companies who market themselves in this sector claim it is far cheaper to pay a billing company than to hire full-time dedicated personnel, with human resources and benefits issues. They claim they have more expertise in managing billing for specific specialties and that the complexity of the system that generates revenue with new diagnostic coding, new CPT codes and the tedious detail of maintaining current credentialing, all drive toward the value of outside experts. They claim reduced submission errors and faster claims processing which results in improved profitability. These arguments can be legitimately compelling. That said, the implications of these agreements merit far greater attention than has been customary. Still further, there are so called 'model" contracts online that purport to be appropriate for these relationships.[3] They are, unfortunately, woefully inadequate, with one exception, that although better, stills needs to be more robust in accordance with the terms I address.[4]

This article looks at the landscape within which these agreements arise, addresses the fundamental issue of compensation to these entities, considers appropriate performance metrics, calls out critical contract and business provisions, and sets forth data issues, including HIPAA, which these arrangements both create and depend upon. Because of the implications of these agreements, I also address the Medicare reassignment rules that govern them, along with the extensive commentary from the Office of the Inspector General in its now 23 year old Model Compliance Guidance for these companies. The article concludes with caselaw both in the government enforcement and contract enforcement contexts. Fasten your seat belt for the swoops and curves that lurk here!

1.0 The Player Landscape

1.1 *Stand alone companies*

The organizations which perform the functions of billing and collection have expanded considerably in recent years. Companies dedicated solely to this activity have themselves grown in number. In 2019, Becker's Hospital Review noted 210 "revenue cycle solutions" in North America.[5] This terminology is a more recent characterization of the broad scope of activities these organizations conduct, which may extend to getting physicians and other clinicians credentialed to bill various payors, as well as consulting regarding the addition of service lines to a practice. The term "revenue cycle management" is more often used in hospital circles.[6]

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[3] See for example, EchoScribe http://www.echoscribe.com/wp-content/uploads/2016/09/Medical-Billing-Services-Agreement.pdf; and Diamond Billing https://somnomed.com/gb/diamond-billing-service-agreement-2/

[4] See HBMA Model Billing Agreement

[5] "210+ healthcare revenue cycle companies to know | 2019". Becker's Hospital Review, (January 8, 2020) https://www.beckershospitalreview.com/lists/210-revenue-cycle-companies-in-healthcare-to-know-2019.html (accessed 11-7-2020)

[6] "Revenue cycle management (RCM) is the process used by healthcare systems in the United States and all over the world to track the revenue from patients, from their initial appointment or encounter with the

There are two major organizations which represent the billing company industry. The American Medical Billing Association (AMBA) claims 3,500 members.[7] They are seen by others as the association of "mom and pop" at-home billing personnel, but they offer a form of certification of expertise. The at-home billing company phenomenon has flourished to such an extent that the Federal Trade Commission has actually warned against bogus solicitations to people seeking work at home opportunities to be aware of phony organizations offering training.[8] The Healthcare Business Management Association represents more than 47,000 employees at nearly 500 "revenue cycle management firms" and professional billing departments.[9] Many health care organizations maintain departments devoted exclusively to conducting the billing and collection function; but more and more of them, including hospitals, are outsourcing these responsibilities.[10] That said, there is an organization which accredits medical billers, whom they define as "The person or entity responsible for the process of collecting fees for medical services."[11]

1.2 *Private Equity, Health Plans, MSOs,*

Stand alone billing companies remain significant players in the industry, but other organizations who depend on physician practices as their significant others, also conduct these functions pursuant to far broader relationships. Prime among them are private equity firms who have entered the health care market with a vengeance.[12] They are widely,

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healthcare system to their final payment of balance.´ Wikipedia https://en.wikipedia.org/wiki/Revenue_cycle_management (accessed 11-7-2020)

[7] Personal communication, Cyndee Watson, President, (11-9-2020)

[8] Federal Trade Commission, "At Home Medical Billing Businesses", https://www.ftc.gov/tips-advice/business-center/guidance/home-medical-billing-businesses (accessed 11-7-2020) . Among the problems they cited as being the basis for charges against companies marketing their teaching of the business to mom and pop operations including overstating earnings potential from at home medical billing; software that did not work; obsolete potential client lists and bogus references.

[9] Formerly the Healthcare Billing and Management Association, https://www.hbma.org/content/about/about-hbma (accessed 11-7-2020)

[10] LaPointe, "Hospitals Turn to Bolt-On, Outsourced Revenue Cycle Management" (Sept 28, 2017) https://revcycleintelligence.com/news/hospitals-turn-to-bolt-on-outsourced-revenue-cycle-management (accessed 11-7-2020)

[11] Electronic Healthcare Network Accreditation Commission (EHNAC) https://www.ehnac.org/?press-release=ehnac-announces-finalized-2021-accreditation-criteria-versions-for-all-accreditation-programs; Glossary, https://www.ehnac.org/wp-content/uploads/2014/01/EHNAC-Glossary-of-Terms-10072020.pdf. As of February 2021, however, there were no organizations accredited under this rubric, despite their efforts since 2013.

[12] See, Reisz, McQueen and Schattgen, "Private Equity investments in Physician Practices: The Next Round", HEALTH LAW HANDBOOK (Gosfield ed., 2017 ed) WestGroup, pp. 297-329; Boufis, "Why Are PE Firms hot For Physician Practices?", Forbes, (Aug 30, 2019, https://www.forbes.com/sites/eliboufis/2019/08/30/pe-firms-hot-for-physician-practices/?sh=123bafaa1191 (Accessed 11-8-2020); LaPointe, "Private Equity firms increasingly buying physician practices," Revenue Cycle Intelligence, (Feb 25, 2020)

variably familiar with or even focused in the health care sector when they execute their transactions. The typical private equity model for physician practice acquisition entails purchasing the physician practice assets, creating a management company in which the physicians invest, often with the proceeds from their asset sales. The new management company, even in states that allow corporate practice of medicine, earns its profits by taking a percentage of the revenues the physicians generate by their work. The goal of private equity is to enhance the value of their assets and sell them to a bigger fish some 5-10 years later.

These transactions tend to work better where the practice depends heavily on cash payments (e.g., dermatology and plastic surgery) rather than where the opportunity for revenues comes exclusively from insurance reimbursement. Having reviewed a range of these transactions across the country, in my experience it is a rare instance, indeed, where the ongoing role of the management company in billing and collection is sufficiently addressed. Significant problems I have seen have arisen from the relative ignorance of the managers in the physician practice compliance space, including inappropriate physician compensation amounts and cash flow problems in part based on mediocre billing and collection practices. Private equity has now been implicated in fraud and abuse settlements. [13]

Besides private equity, other similar transactions involve a physician practice management company, or a management services organization (MSO) which buys the physician practice assets, sometimes employing the ancillary personnel and sometimes not. [14] Health plans have also gotten into the business of buying or merging with physician practices.[15] For our purposes the salient characteristic of all these organizations is that, like private equity firms, they may have little to no expertise in physician billing; and when they employ any of the clinical staff there can also be issues with management of personnel. I have seen such problems in the resulting arrangements between the MSO and the practice.

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https://revcycleintelligence.com/news/private-equity-firms-increasingly-buying-physician-practices (accessed 11-8-2020)

[13] See, Dep't of Justice, Office of Public Affairs, United States Files False Claims Act Complaint Against Compounding Pharmacy, Private Equity Firm, and Two Pharmacy Executives Alleging Payment of Kickbacks, Feb. 23, 2018. Available at https://www.justice.gov/opa/pr/compounding-pharmacy-two-its-executives-and-private-equity-firm-agree-pay-2136-million (accessed 11-8-2020)

[14] McDonald, "MSOs Give Physicians Time to Do What They Do Best", (Mayr 4, 2018) https://www.lbmc.com/blog/msos-give-physicians-time/; Hernandez, "Is a Management Services Organization (MSO) Right For Your Practice?", (June 24, 2020) https://thedoctorweighsin.com/management-services-organization-mso/ (both accessed 11-8-2020)

[15] Livingston, "Reigniting the physicians' arms race, insurers are buying practices," Modern HealthCare, (June 2, 2018) https://www.modernhealthcare.com/article/20180602/NEWS/180609985/reigniting-the-physicians-arms-race-insurers-are-buying-practices (accessed 11-8-2020); The Advisory Board, "Why more insurers are wading into the provider market" (March 6, 2020) https://www.advisory.com/daily-briefing/2020/03/06/insurer-clinics (accessed 11-8-2020)

1.3 *Health Systems*

A major category of transaction which implicates billing, but typically only touches lightly on the potential pitfalls, is where a health system leases physicians whom it does not employ and bills for their services to be paid to a health system affiliated tax ID number. Often in these settings they do employ some other physicians for whom they have a wide range of billing experience. There are variations in these models as well, including on one hand where the health system buys the assets of the practice and only leases the physicians to, on the other hand, full turn-key operations where the practice leases itself and its entire operations to the system, but remains intact and otherwise independent.[16] Often in negotiating these transactions, the health system asserts its prowess in billing and states it must take over the function because of the confidentiality provisions regarding their rates. This is absurd. I have never had a physician practice client which needed to see the rates, although if they continue to do collection, which also almost never happens, in my experience, the group practice would come to understand the system's rates by implication.

The real problem is that most of these systems are woefully inexperienced in physician billing. I have had more than one instance in the early days of my working on these deals where my clients accepted the health system's assertions and were seriously harmed by the system's inefficiencies and incapacity to bill effectively. In the worst scenario I have seen, my client group had been collecting about 55% of what they billed – not great, but not terrible. The group terminated their billing staff. In the first more than a calendar quarter of the lease relationship, the hospital collected 14% of the claims generated! With significant education of their staff, they got that rate up to 29%. More on the implications of these failures later in my discussion of performance metrics and contract terms; but I now advise my clients not to accept any health system assertions on point, and recommend, and have written, representations and warranties for protection.

2.0 <u>The Pay Rate Conundrum</u>

2.1 *Percentage Compensation and State Law*

Probably the most enigmatic aspect of these relationships which can lead to perverse incentives absorbed, is the long-standing tradition of paying these companies based on a percentage of the revenues that result from the claims they generate. While some years ago typical percentage payment rates were 3-6% and sometimes into the teens, today it is not uncommon to see rates as low as 1% to up to 9%.[17] A representative of the AMBA says the average is between 6-8% with a lower rate where revenues tend to be higher per

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[16] For a deeper consideration of these transactions see, Gosfield, "Anatomy of An Acquisition Alternative: Leasing The Practice", *Journal of Medical Practice Management*, (Sept-Oct 2016) pp. 83-85; Gosfield, ""Lessons Learned from Leasing: A Blueprint for Hospital-Physician Alignment," HEALTH LAW HANDBOOK, (2018 Edition) WestGroup, pp.122-155

[17] Personal communication Robert B. Burleigh CHBME, President, Brandywine Healthcare Services, West Chester, PA (9-29-20)

service (e.g., for surgeons as distinct from PCPs).[18] The highest rate I ever saw was years ago from a company that did the CPT coding directly from the medical records and not from SuperBills[19] or encounter forms and solely for emergency medicine claims. They charged and received 20%!!! Some firms charge different percentages depending on the payor; so, since personal injury claims take so long to pay, they may charge more for them and less for workers' compensation claims which pay with almost no review versus medical insurance claims that may pay more quickly but are potentially subject to greater scrutiny by the payer. Other companies don't charge the percentage on extremely highly paid items like infused drugs.[20]

The big fallacy in these arrangements is that the level of effort it takes to create a claim for a plain film chest x-ray that will pay the physician $10 is precisely the same as to enter the same line of data for a neurosurgical procedure that will pay $15,000. What possible reason is there to pay the billing company differentially for those two claims? It creates an incentive to maximize recoveries which may encourage efficiency, but it can also lead to perverse reactions to over-code to get more money. Some have argued the approach incentivizes upcoding (inflating the level of the service billed to generate higher payment for which the company receives its percentage.)

Some states prohibit percentage based billing contracts in their Medicaid programs.[21] Some states have more broadly applying prohibitions on fee splitting which would outlaw percentage based billing company contracts.[22] Other states have such provisions but only with respect to certain categories of professionals. In Pennsylvania, podiatrists may not have percentage based management contracts.[23] South Carolina prohibits fee splitting for

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[18] Personal communication, Cyndee Watson, President, (11-9-2020)

[19] "A superbill is a primary data source for the creation of a data claim enlisted by health care agencies, doctors' offices, hospitals and health care providers.":://www.techopedia.com/definition/25048/superbill (accessed 11-10-2020)

[20] See n. 17.

[21] See restitution letters from NY State citing 18 NYCRR 504.9(a)(1), 18 NYCRR 360-7.5(c) https://www.jdsupra.com/legalnews/percentage-based-billing-contracts-42419/Unit and A Message For Providers using Service Agents. (2001) https://drive.google.com/file/d/0BzGWQOHV1T-wQmdlQWd4ekIyNG52OXdYVlVndUdNX2tnemZ3/view

[22] See, Grossman and Rock, "FEE SPLITTING AND THE MANAGEMENT OF MEDICAL PRACTICES: A HISTORY OF BOARD OF MEDICINE DECLARATORY S (April 1998) https://www.floridabar.org/the-florida-bar-journal/fee-splitting-and-the-management-of-medical-practices-a-history-of-board-of-medicine-declaratory-s/; see also, Ustin and Brass, " An Examination of Fee-Splitting Statutes in the Context of Value-Based Health-Care" BNA Medicare Report (2015) file:///C:/Users/agosfield/Downloads/f68e9bf4-f24a-4e76-b462-0c598f755727.pdf

[23] 49 Pa Code 29.26(b)

physical therapists.[24] Georgia's law governs optometrists,[25] while Missouri's is aimed at dentists.[26] By contrast, California and Illinois have statutes that prohibit fee splitting, but specifically authorize percentage-based billing arrangements.[27] Whether percentage based billing company contracts are a form of fee splitting is a caselaw judgement, but the approach is criticized on grounds that go beyond the illogic of basing payment on the amount the physician charges.

2.2 *Fixed Rate, Per Claim or Hourly*

Another approach has emerged in the form of fixed fee billing. (e.g., $X per month for up to Y claims) or per claim. In these arrangements the price does not reflect the volume of business per se, although, obviously, more claims are generated in general when more revenues are billed. These, however, are decidedly not the norm, yet. The AMBA reports that their members are moving more toward a flat fee, monthly or hourly, because of OIG concerns. [28] (See further below) One of the challenges in these approaches is whether the rate appropriately accounts for collection efforts if the company is managing that in addition to submitting the claims. Some models include within the fixed rate two good faith efforts to collect and then some percentage fee for collection beyond that. The other criticism is that these rates do not encourage efficiency. The same can be said for an hourly charge which is even less common from a third party biller.

The entire payment issue needs some creativity. We have used another approach which confronts some of the federal fraud and abuse risks in billing company arrangements.

2.3 *Stepped-Capped*

Under the anti-kickback statute, a management company which markets the entity they manage may not be compensated on a percentage basis even where any other similar entity not marketing would be paid on a percentage. The OIG has even written an Advisory Opinion 98-04 which criticized percentage billing where the billing entity also marketed the practice. Their concern was risk of increasing referrals, no safeguards against over-utilization and incentives to increase the risk of abusive billing practices. It is the generation of business through marketing that is the problem. In our model which we believe other counsel have also used in management agreements, we refer to the approach as a "stepped-capped" arrangement.

Here, the billing company charges a fixed rate per month for some quantum of claims volume. When the revenues go up enough that it would change the valuation for fair market value purposes because of the need for increased computer time, staff time, paper,

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[24] SC Code Ann §40-45-110(A)(1)

[25] Ga.Com.R & Regs §430-4.01(3)

[26] MO Rev. Stats. 332.321.21 (18)

[27] See Cal Welf & Inst. Code 14040.5(b); and 225 ILCS 60 (1987). 22.2(d)

[28] Cyndee Watson, President, personal communication (11-9-2020)

resources, heat, light and overhead, then the management fee goes up to a new fixed number and stays there until another step can be justified. The steps cannot be so close together as to resemble a percentage arrangement. That said, although never approved by the OIG, DOJ or any other government agency, nor addressed in any Advisory Opinion or other guidance, the approach seems consistent with the former anti-kickback safe harbor requirement that the aggregate compensation be stated in advance not taking into account directly the volume or value of business between the parties. Now with the change in regulation so that aggregate compensation need not be stated in advance, but, instead, a methodology may be set forth[29], the stepped capped approach can be stated as more or less a cost-plus methodology. It may require a sophisticated valuator to establish the initial step and those which follow with a properly justified dollar amount. If you state this in terms of assessing costs brought to bear (e.g., FTEs for data entry personnel, computer time, etc) and add a percentage on top for profit, that could be a methodology meeting the new standards.

3.0 Performance Metrics

While percentage based contracts motivate high charges and high collection rates at the extreme ends of the incentives continuum, they are an insufficient measure of the performance of the billing company on a broader scale. For many years, billing company agreements were little more than a glorified letter. Most companies merely agreed to create and submit claims for their clients. This is still relatively common although most agreements are at least a few pages. There were almost no performance metrics or expectations in any of the earliest agreements. Initial resistance to metrics turned on the companies' asserted difficulty in establishing them and further difficulty in measuring performance. That is no longer the case. The industry itself has promulgated measures, although they are not necessarily willing to commit to those metrics contractually.

There are a variety of measures of the efficiency of the claims submission process.[30] "Days in receivables outstanding," or "days in accounts/receivable" offer an overall measure of the timeliness of the billing process. "First pass resolution rate" or "clean claim ratio" reports how may claims get paid on the first submission. "Net Collection Ratio" is payments divided by the result of charges minus contractual adjustments. It reports "essentially what was collected of what was collectible."[31] Percentage of accounts receivable older than 60 days, is the other end of timeliness measures. The gross collection rate is the simplest view of whether the company is working well; and its corollary is the denial rate. The collections per visit by comparison with others of the specialty is more difficult to ascertain but is also useful in assessing the bona fides of a billing company to meet the needs of a particular specialty practice.

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[29] 42 CFR § 1001.952(d)(4)

[30] I would like to thank Bob Burleigh (see n. 17 above) for his insights into these issues.

[31] Id.

Not all of these metrics need to be in a billing company contract, but, particularly where the billing entity is a health system, to require performance in accordance with the standards of the industry regarding at least timeliness of claims submission, collection rate and aging of accounts receivable are fundamental. In many of the transactions where the practice is leased to the health system[32], the agreement guarantees a fixed rate of compensation to the group predicated on a fixed quantum of wRVUs performed by the physicians, sometimes subject to reconciliation periodically and other times subject to a corridor above that quantum before additional monies will be paid and a threshold below which the compensation needs to be recalculated. In every instance, the risk of payment rests with the health system. If the health system is ineffective in its billing it can turn around and say to the physicians "we have to alter your compensation because what we are paying you is not fair market value given what we are collecting." Because of this risk, which I have encountered, I routinely write agreements that have the health system represent their ability to bill effectively in accordance with the standards of the industry , when they insist on controlling this essential function. If they can't meet those standards, then the parties should select a third party billing company. One essential approach to avoiding this problem is to have the physician practice continue to perform the billing under a management agreement which pays them for these services. I have done this multiple times.

Against these measures of the company's performance, the company ought not be held responsible for physician billing inefficiencies. Consequently, it is legitimate for the billing company to require that the data upon which they will bill be provided within specified timeframes of mere days (3-5). If the physicians are providing the CPT and ICD codes to populate the claims, it is legitimate for the company to require a representation from the physicians that those codes are accurate and supported by the documentation. These issues play directly into damages calculations if and when things go wrong. (See 8.0 below).

4.0 Allocation of Responsibilities

4.1 Data and Its Management

Data –- such as type and number of services performed, CPT codes, ICD codes, fees, demographics – are the essence of what the billing company will manage. How data is handled is potentially the most significant factor in the entire relationship. How will the company get the data to populate the claims it creates? Do they have direct access to the electronic medical record (EMR) or the practice management software? The contract should address how encounter data will be transmitted, and whether electronically, by paper or both. Who does the coding is a critical issue. Most contracts specify that the company will rely on the CPT and ICD coding provided by the practitioners. Others,

[32] For a more in depth discussion of these transactions, see Gosfield, "Anatomy of An Acquisition Alternative: leasing The Practice", *Journal of Medical Practice Management*, (Sept-Oct 2016) pp. 83-85; Gosfield, "Lessons Learned from Leasing: A Blueprint for Hospital-Physician Alignment", HEALTH LAW HANDBOOK (2018 Ed.), pp. 121-155

however, offer coding services as part of their suite of services.[33] If the company codes, they may charge more and the risks to both parties are different.

The timeliness with which the physicians generate data for the company to use will affect cash flow and, depending on the payment structure, income to the company. How long after the service is rendered that data is provided to the company ought to be addressed in the contract. The company should also represent and warrant it's conformity with the standards of the industry and the requirements for the specifically applicable payors for the specific clinical specialties at issue in the claims submissions.

The contract should explicitly state that the data used to submit the claims and the data in the claims belongs to the practice and cannot be held hostage by the company in case of a dispute. I have inserted injunctive relief provisions to protect against problems here, since in the early days of working on these relationships, it was not uncommon to have the company refuse to turn over data in the context of disputes. That said, the agreements I review rarely confront the ownership of other data such as the encounter forms provided to the company (as distinct from the data they contain), particularly if they are forms provided by the company to facilitate their submission of claims in accordance with their software requirements. Some companies ask for the right to use de-identified data in marketing, and particularly where they are part of a larger management company, potentially for other purposes (e.g., profiling of practitioners across their customers to analyze performance issues they can address in their management).

Clearly, the company is a business associate of the practice under HIPAA and a BAA should be part of the agreement in virtually every instance. But, that may not be enough to confront potential problems down the line. It is worth considering specific representations and warranties from the company regarding having done a security risk analysis as well as training of their personnel. They should have a HIPAA compliance program which the client practice should review. HIPAA compliance, given the risks, should be addressed in much the same manner as billing compliance.[34]

The issue of the company providing reports to the practice is not merely for practice management purposes. Reports regarding the accuracy, currency, payment rate and the like on all the claims submitted, including by each physician in the practice are fundamental. Profiling physicians within the practice can be enormously helpful to determine aberrant billing patterns or more successful documentation to be used as learning tools. If these are to be provided, they need to be addressed in the contract. Less well understood are the obligations created by denied claims.

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[33] See discussion at 7.3 of the OIG Model Compliance Guidance for special guidance to companies who code and the risks they have and create.

[34] See 8.3 for discussion of HIPAA repercussions from failures here.

The government takes the position that a single denied claim triggers an obligation on the part of the practice to investigate whether a voluntary repayment is necessary.[35] If that is true, then every instance of a claim denial needs to be made known to someone in practice administration who understands the voluntary repayment obligations. What role will the company play in the investigation and identification of any potential overpayments and at what cost? This is rarely addressed in the contract; and it should be before problems arise. Putting any internal investigations under attorney-client privilege is a prudent approach, as is having the right to bring in another auditor, under the privilege, to review what the company has done. This has to be in the agreement as well, to forestall fighting about it later. The involvement of the company in the internal investigation can be helpful since they are familiar with the data, but that can also depend on the nature of the problem and whether they have contributed to it.

Denied claims are not the only data the company ought to be required to report timely to the practice, Payers often send communications only to the "pay to" address. Payer profiles of the practice, payer inquiries regarding profiling of the practitioners or other data or statements to or about the practice should be conveyed timely, based on an obligation set forth in the contract. In order to prevent the company from fomenting whistleblowers within it, I have put into contracts the requirement that if the company has concerns about any billing activities of the practitioners or anyone else in the practice, they are obligated to bring those issues to someone high in administration before they take that information anywhere else.[36]

4.2 *Operational Responsibilities: Cash Management*

In most of these relationships, the company typically disclaims responsibility for prior accounts receivable, leaving them to be managed by the practice. Still, some companies agree to pick up prior unbilled or uncollected accounts receivable. If they agree to do so, it is typically at a premium rate because they are dealing with problems created by others.

How monies are received is an issue with several facets First, who is managing co-pays? If they are collected at the time of service, this is a practice duty. If, however, the practice bills for the co-pays after the fact (not typically a best practice), then the billing company has to manage this function properly, applying co-pays and deductibles effectively.

Where will payments from patients be made? Often there is a bank lock box established which is owned by the practice but to which the company as access. Payers send their payments directly there. There are still instances where the billing company only has access to office records of checks deposited by the practice as well as explanations of benefits that might be sent to the practice directly. What will happen with credit balances? As we will see further, this is a particular concern of the OIG, but whether credit balances

[35] For a deeper consideration of the many issues associated with voluntary repayments, see, Gosfield, "Voluntary Repayments: The Physician Perspective", Journal of Health Care Compliance, (Jan-Feb 2017) pp.5-9; Gosfield, "The Oxymoronic Landscape of Voluntary Repayments," HEALTH LAW HANDBOOK, (2017 Edition) WestGroup, a Thomson Company, pp.72-99

[36] See 7.5 for what the OIG says about these issues in the context of the Model Compliance Guidance.

will be paid in cash or applied to future bills, ought to be addressed. The practice should adopt policies regarding how long a credit against future bills will be maintained so as not to accumulate credit balances that become so old they cannot effectively be repaid, creating an unearned windfall for the practice.

4.3 Operational Responsibilities: Enrollment and Credentialing with Payors

When practitioners, whether physicians or others join and leave a practice, their enrollment with payers is critical to the group's ability to bet paid at all. Billing companies differ in their expertise regarding these duties. Representations in the contract regarding their knowledge can be useful, both to emphasize the importance of this activity but as a basis for liability if they are negligent or create errors. Failure to get this process right can devastate a practice. That said, the data the company must use to perform this function comes from the practice itself; and it is fair for the company to require timely data submission and protection if the practice errs in performing its obligations.

There are thorny issues in enrollment maintenance and especially under Medicare that are beyond the scope of this article.[37] But, just to sensitize the reader to some of the conundra here, physician assistants do not reassign their right to benefits under Medicare, by contrast with nurse practitioners who do. That said, if a PA leaves the practice, Medicare must be notified.[38] Medicare applies timeframes to reporting changes in specific personnel. the violation of which can lead to the loss of billing privileges or assignment. Other payers have their own requirements regarding notification of changes. Getting new physicians or non-physician practitioners appropriately recognized by payors can impact cash flow and profitability. Many of the potential pitfalls that lurk here are unaddressed in the billing company contract. The balance of responsibility and the effect of negligence by either party ought to be more carefully addressed than most agreements I have seen.

4.4 *Operational Responsibilities: Indemnifications*

In the practice's due diligence regarding the billing company, the company's maintenance of insurance to cover the varieties of their potential negligence is critical. Reviewing the coverage they have is the best way to be assured as to what pertains; but if that is not possible, at a minimum a representation regarding this obligation can bolster the circumstances if things go awry in the future.

The company should indemnify the group for its negligence in claims submission. Many do not. This is nowhere near as simple as one might expect. Traditionally, companies disclaimed any responsibility for failed claim submission or limited their liability to merely the value of their compensation for several months' worth of submitted claims. This is unfair if the problem has persisted longer, but a problem of longer duration also calls into question whether the practice has been negligent in its management of the relationship.

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[37] For deeper considerations of these issues See, Shay ,"The Ongoing Ordeal of Maintaining Medicare Enrollment," Dermatology World, March, 2019, pp. 22-23.; and,, Shay, "Maintaining Medicare Enrollment Data: Managing the Ongoing High-Hurdles Race", Compliance Today, January-February, 2020.

[38] See the CMS-855B enrollment form.

This is why to have the right to monitor the company can be a shield. But the failure to use it can be a sword if things go wrong.

Every contract I have ever seen disclaims punitive damages if it addresses indemnifications at all. That said, there is another problem lurking in the damages implications of indemnification for negligence: the unearned overpayment. If the company's errors led to the practice being paid amounts they were not entitled to by using a code that is unsupported in documentation or adding diagnostic codes which increase the complexity and therefore the amount of payment made, are those actually damages if the group was not entitled to them in the first place? The essential issue is what caused the overpayment,. Sometimes there is shared responsibility for the negligent claim submission which raises other problems including under the practice's own errors and omissions insurance, which should be evaluated for whether it covers billing disputes, appeals of denied claims, appeals of audits and the like.

5.0 Termination

Termination without cause is a real problem without significant lead time, especially if the party seeking to terminate is the billing company, because another one will have to transition into the role. Termination without cause by the practice is problematic for the company because they lose a customer and have to plan for replacement business, plus transition data out of their systems. Many agreements do not permit termination without cause other than toward the end of a multi-year relationship. One of the challenges is that Medicare (see below) requires that the person for whom claims are being submitted has the right to revoke the billing authority at will.

Termination for cause for the practice usually turns on the company's failures of performance, if those standards are clearly set forth in the agreement. Failure to collect effectively as measured against a performance metric is also a basis to terminate. Breach of HIPAA creates a different basis to terminate. For the company, the bases for termination typically include improper coding and billing requests from the practice, ineffective documentation by practitioners after notice, or lack of timeliness in data submission. The biggest problems in termination under these agreements, in my experience, is the failure to have provided an appropriate basis, whether a metric or a specific provision, on which to allege cause or breach.

Post-termination issues can be critical. Transfer of data has to be accomplished with as little disruption to the practice as possible. For how long after notice of termination will the company continue to submit claims? If there are allegations of company negligence there is the problem of letting a company who has failed to perform continue to do so. The company's clear obligation to turn over all the data and in what format, might well be made subject to injunctive relief it is so fundamental. I have not seen such a clause enforced, but these failures cannot really be cured by money damages if the practice grinds to a halt with no cash coming in from its core business. The extent to which the company will be expected to participate in post-termination audits, whether internal or from a third party, as well as participation in appeals of claims denials post termination ought to be addressed directly. Often, as in the potential sale of the practice, a need may arise post-termination to

have custom reports about the practice that were not part of the ongoing responsibilities of the company. To the extent those matters can be addressed in the original agreement before the need arises, that is far better than having to negotiate with a company with whom the relationship may have soured. But these needs are much harder to predict.

6.0 Medicare Reassignment

When Medicare was enacted in 1966, not much attention was paid to the potential for a market in commercial paper based on Medicare claims. By 1977 the Fraud and Abuse Amendments first adopted what were then referred to as the "anti-factoring rules"[39] to prevent individuals and entities other than the providers or their employers from being paid by the Medicare program for services rendered by others. The general prohibition against paying anyone other than the provider who rendered the service or delivered the goods or supplies remains in place. "Medicare does not pay amounts that are due a provider to any other person under assignment, or power of attorney, or any other direct payment arrangement."[40] There are exceptions for services provided "under arrangements" where one party bills for something another party did.[41] There are also purchased services subject to the anti-markup rule where one party can purchase a service from another and be paid for it.[42]

The exception which is most applicable in our context here is the one permitting payment to an "agent".[43] One of the principal requirements is that payment must always be made in the name of the professional rendering the services (or the group to which they have reassigned). Based on that restriction, the whole approach is not really reassignment akin to when an employee reassigns to the employer who gets paid in its name. The agent may engage in billing and collection. Medicare requires a written agreement with the practice or professional. Two additional restrictions have generated confusion in all the years I have worked on these issues. The first is that the agent's compensation may not be related in any way to the dollar amounts billed or collected, although when the regulations were first published in 1980 the government observed in the preface that they expected these contracts to provide for compensation on a percentage basis, which clearly relates to the amounts billed or collected The rules go further to prohibit payment being dependent on the actual collection of the payment. Finally, the agent must be acting under instructions that the provider may modify or revoke at any time. How then do billing companies paid on a percentage of what they bill or collect function in the Medicare sector?

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[39] Sec 2, PL 95-142—OCT. 25, 1977

[40] 42 CFR §424.73(a)

[41] 42 CFR §412.50 and 42 CFR §409.3

[42] See MedLearn Matters Article 6733 (March 15, 2010) https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM6733.pdf

[43] 42 CFR §424.73(b)(3)

There is an escape clause, not in the regulations, but in the Claims Processing Manual which was formerly in the Carriers Manual. It provides that the restrictions regarding compensation terms that reflect billed or collected amounts do not apply "if the agent merely prepares bills for the provider and does not receive and negotiate checks payable to the provider/supplier."[44] I have never seen a billing company contract that has the billing agent negotiating checks, which from law school bills and notes class means they can endorse it to themselves. I have seen and written contracts where the billing agent is permitted to pay itself from the proceeds in a lock box. I have seen and written contracts where the practice and the billing company are jointly on the account; but I have never seen a billing company negotiate the checks. Where, however, the billing company is in a different relationship with the practice – as in a practice lease--there is an agreement that the health system billing for the services and getting paid for them does have the right to negotiate the checks. That relationship, however, is more one of independent contractor reassignment and not billing agent and physician practice. I have never seen this issue raised in any lease transaction in which I have been involved, nor have I ever seen Medicare enforcement of the prohibition on negotiation of the checks in that context.

Rather, quite the opposite is the case: the Medicare Administrative Contractor (MAC) is instructed to assume the conditions for payment are met in the absence of evidence to the contrary. If there is evidence to the contrary, the billing agent must document its agreement by submitting it to the MAC If there is no written contract or the agreement is unclear, the MAC will obtain statements from the agent and will verify the company's assertions by obtaining statements from providers that have agreements with the company. It should be noted that the Manual makes clear that an improper reassignment is not an overpayment; but it does have to be corrected upon notice from the MAC. Failure to comply can cause a provider to lose the right to participate in Medicare and/or the right to be paid assigned claims; but that is rare. An egregious violation like using powers of attorney would be an example of something that likely would trigger a more severe response from the government. The government, as we shall now see, has a fair amount to say about these relationships.

7.0 The OIG's Model Compliance Guidance.

That the OIG considered the role of billing companies in fraud and abuse as a high priority can be seen in the fact that they were the fourth industry sector addressed after hospitals, laboratories and home health agencies. Their Model Compliance Guidance was published in 1998[45] and has not been updated since. The OIG explained the urgency by saying their services "could greatly impact the solvency and stability of the Medicare Trust Fund."[46] The agency noted then that the HBMA said its members were processing more than 17.6 million claims per month totaling $18 billion a year. All numbers are surely higher now.

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[44] Medicare Claims Processing Manual, Chptr 1, §30.2.4.

[45] 63 Fed Reg 70138-70152 (Dec. 18, 1998) *hereafter "MCG"*

[46] MCG at 70138

Then the enforcers noted the tremendous variation in the scope and scale of companies doing this work. Their guidance encompasses 14 pages, but more noteworthy are the 105 footnotes! Overall, the Guidance emphasizes open communication between the company and customers, including that the company should share its compliance program with its customers. Further, "once the responsibilities have been clearly delineated, they should be formalized in the written contract between the provider and the billing company."[47]

To truly understand the import of the Guidance it is useful to reflect on the historical moment in which it was published. All four of the noted Guidances were published in 1998. Nothing like them had been published before. In a sense the OIG was confronting a marketing problem of indicating how the Guidances could protect the specific sectors of the industry. So, part of the Guidance presented fourteen potential benefits of a compliance program to a billing company. They are worth reviewing, both to consider their salience 23 years later, and also to reflect on the concerns the OIG had in creating this new environment of Compliance Guidances.

7.1 Benefits of A Compliance Program[48]

The first benefit would be true, as much they propounded was, and applicable to any healthcare entity with a compliance program; namely, having a program would force the formulation of effective internal controls to assure compliance with Federal regulations, private payor policies and internal guidelines. They posited that having a compliance program would improve medical record documentation, although how was not explained. One might speculate that the requirement to provide data to a billing company outside the practice to create claims would necessitate sufficient documentation to create the claim, but more than that is speculative.

They cited improved collaboration, communication and cooperation among health care providers and those processing and using health information, which is hardly arguable. Having a program would give a company the ability to more quickly and accurately react to employees' operational compliance concerns and the capability to effectively target resources to address those concerns. This is an argument for all compliance programs. Their fifth benefit posited a more efficient communications system that establishes a clear process and structure for addressing compliance concerns quickly and effectively, and further claimed as a sixth benefit that having a program would be "a concrete demonstration to employees and the community at large of the billing company's strong commitment to honest and responsible conduct." How the community at large would be informed of the existence of the program was not addressed then, but today, many healthcare organizations post on their websites, among other external communications, that they have a Compliance Program. The next four benefits would, again, be applicable in any Compliance Program context: (7) The ability to obtain an accurate assessment of employee and contractor behavior relating to fraud and abuse; (8) increased likelihood of identification and prevention of criminal and unethical conduct; (9) a centralized source for distributing information on health care statutes, regulations

[47] MCG at 70139

[48] MCG at 70140

and other program directives related to fraud and abuse and related issues; and, (10) a methodology that encourages employees to report potential problem.

The last four benefits were more specifically focused around the activities of billing companies as distinct from the provider entities they had addressed in the other three Compliance Guidances. A program creates procedures that allow the prompt, thorough investigation of possible misconduct by corporate officers, managers, employees and independent contractors, who can impact billing decisions; a Program would create an improved relationship with the applicable Medicare contractor. This actually makes no sense to me. There is little reason at all for a MAC to be involved in any way with a billing company's compliance program. (13) Early detection and reporting by the company, thereby minimizing the loss to the Government from false claims, and as a result reducing the billing company's exposure to civil damages and penalties, criminal sanctions, and administrative remedies, such as program exclusion; and, finally, (14) having a Program would enhance the structure of the billing company's operations and the consistency between separate business units. Again, this makes no logical sense as a projection by the government.

7.2 Suggested Plan Contents: Written Policies

The Guidance incorporated the seven basic components of all compliance plans as suggested by the government in all the Guidances and will not be repeated here. With respect to billing companies in particular, the government suggested that written policies and procedures should function as the organization's "constitution".[49] This is hardly the case for hospitals, laboratories or home health agencies, whose entire business is not bound up in the risk of false claims as the billing company enterprise is. The policies should address education and training requirements for billing and coding personnel, and risk areas for fraud and abuse (more on that in a moment). The OIG makes reference repeatedly in the document to concern for the 'integrity of information systems,' generally, evidencing some apparent suspicion regarding how these programs operated in an environment when electronic billing had not yet been mandated by Congress.[50] The lack of an expectation regarding electronic systems was also evident in the government's suggestion that policies provide a methodology for resolving ambiguities in the provider's "paperwork." Another theme addressed here, which comes up over and over again, is the reference to managing credit balances effectively.[51] Policies ought to further address procedures to ensure duplicate bills are not submitted. Special warning was issued to billing companies who code to pay attention in their policies to what a coder should do if they are unable to locate a code for a documented diagnosis or procedure or if the medical record documentation is insufficient to determine what to do. Essentially they advise contacting the documenting clinician, but it is only in a footnote, though, that this point is made clear.[52]

7.3 Suggested Contents: A Risk Analysis

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[49] MCG at 70142

[50] As noted in the opening discussions, that did not happen until 2003, fully five years later.

[51] See 4.2 above.

[52] See OIG's fn 21 at MCG 70142

The OIG gives special direction to these companies to do a risk analysis first, suggesting 17 topics as subjects for review. Some of these are self-explanatory;, some require elucidation and one or two don't make sense. It should be noted that there are 23 separate footnotes by way of explaining these topic areas. Some are more successful than others. Topics include: billing for items or services not actually documented; unbundling, which is billing separately for things included in one code; upcoding, which is selecting a code higher than justified by the documentation so this could also be referred to (although it never is) as 'under- documentation'; inappropriate balance billing, which has slightly different significance for physicians who, if they do not participate in Medicare, are permitted to bill the patient on a claim for which they did not accept assignment an amount higher than what Medicare pays; inadequate resolution of overpayments (an issue before there ever were rules about how to handle voluntary repayments); lack of integrity in computer systems, about which they still have concerns which are never further explained; in a related topic, computer software programs that encourage billing personnel to enter data for services not documented should be addressed. Again, this is a fairly naive understanding of how sophisticated EMR programs work when they are linked with billing. Many will prompt the documenter to write documentation that substantiates a higher code, while others may offer suggested coding choices which motivate a coder to select a higher code. These are still problems today.

The suggestions continue: failure to maintain confidentiality of records should be considered. HIPAA had been enacted in 1996 but was barely implemented when the Guidance was written. Other topics include misuse of provider identification numbers and outpatient services rendered in conjunction with inpatient services[53]. Duplicate billing appears again; so does billing for discharge in lieu of transfer which is a hospital issue, since services rendered post discharge are paid differently from services provided by a facility to which the patient is transferred. This is not an issue for physicians. Failure to properly use modifiers is merely listed without any explanation. But this implicates two issues:(1) failing to use modifiers when they are required to lower the reimbursement, as when one physician does the surgery but a different physician provides the follow up care in the global surgery period; or (2) the obverse which is using a modifier when it does not apply, as in billing for a visit during the global period after surgery indicating it was unrelated to the reasons for the surgery and thereby obtaining funds improperly.

The OIG added several issues which are somewhat opaque, at least to me. The billing company is advised to address incentives that violate AKS or similar Federal or state law. The only explanation is in a footnote that says that where billing companies do marketing, AKS may be implicated.[54] Joint ventures should be considered, they suggest; but this guidance is unclear (the billing company may not know anything about any joint ventures

[53] This is a form of unbundling in the hospital setting where among other things, outpatient services rendered by the same provider(not physician) in the 72 hours before admission are rolled into the inpatient reimbursement.

[54] See OIG's fn 40 at MCG 70143

of the customer); and the relevant footnote ends with the admonition don't give gifts.[55] Their last two topics are common and fundamental: routine waiver of copays or billing insurance only; and discounts and professional courtesy.

Companies who code have an additional group of seven issues to which they ought to devote attention according to the OIG: internal coding practices; assumption coding which they note means coding without even looking at documentation; alteration of documents; coding without proper documentation of all professional services (which implies that all coding is to be based on review of documentation); billing for services provided by unqualified or unlicensed clinical personnel. This one is unclear to me. First, how would the billing company know the person documenting was not appropriately qualified or licensed? They might know if the clincians at issue were physicians for whom they did the credentialing; but otherwise, this does not make a lot of practical sense. Second, why is this set forth only for the companies who code? That also doesn't make much sense. These companies are further urged to address availability of all required documentation at the time of billing; and are cautioned against the employment of sanctioned individuals. Again, why only for the companies who code?

For all companies, the OIG further focuses attention, with more explanation, on additional risk areas including the claim submission process itself,[56] credit balances (again!), and more on the integrity of data systems[57] including regular backup (by the quaint methods of diskette or tape!), regular virus checks, and control of access. Going beyond risk analysis they suggest that compliance should be seen as an element of a performance plan and made a regular part of the assessment of employees. In one of the most important distinguishing aspects of this Compliance Guidance, they acknowledged that the suggested approach to auditing and monitoring is a little different from other sector Guidances because the essence of the business is claim submission; while the essence of the other sectors is to be a provider of health care services.[58]

7.4 Other Suggested Content

The OIG emphasizes education and training, devoting fully a page and a half of the total of fourteen pages[59], just to this topic. In addition to training on the legal context and requirements, education regarding the organization's commitment to compliance is paramount. Coding and billing training gets special attention, not surprisingly. With five additional footnotes, companies are advised to address specific government and private payor reimbursement principles; general prohibitions on paying or receiving remuneration

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[55] See fn 41at MCG 70143

[56] MCG at 70144

[57] MCG at 71045

[58] Id.

[59] MCG at 70147-8

to induce referrals, proper selection and sequencing of diagnoses; improper alteration to documentation; billing as for a physician when rendered by a non-physician, calling out specifically the "incident to" rule; proper documentation of services rendered, including the correct application of official coding rules and guidelines. That one is a jumble actually of topics primarily for clinicians documenting what they did and then, potentially, coders who might select procedural and diagnostic codes for the claim. Clearly when physicians do both, they need training in how to do that; but that is not addressed in this Guidance which is to the company. They add the issue of signing a form for a physician without the physician's authorization and the duty to report misconduct. (See 7.5)

The Guidance continues to address topics included in all the Guidances, such as maintaining effective lines of communication including establishing hotlines, providing access to the Compliance Officer, and creating a compliance committee. Like the other Guidances, here the OIG speaks to enforcing standards through well publicized disciplinary policies. Unlike the other Guidances, the OIG next moves onto auditing and monitoring, about which they assured earlier in the document their approach would be different. Again, this topic alone takes a full page of text.[60] Regular, periodic audits, whether internal or external are recommended. Monitoring techniques including sampling protocols are described in some detail. There are nine potential additional techniques which are presented.[61] Five additional recommendations regarding qualifications and authority of reviewers are offered. Finally, the billing company should document its compliance efforts, the OIG suggests.

7.5 Reporting Obligations

The government asserts the responsibility of the company to investigate problems they find in auditing and monitoring,. Correcting errors is recommended, but a different problem for billing companies is their obligation with respect to reporting misconduct. The OIG separates the responsibilities where the misconduct is in-house as opposed to where the misconduct is on the part of the customer!

First, they note the criminal liability of an individual for converting funds to their personal use, embezzlement, or committing an offense against the United States, with a statutory citation in a footnote.[62] They then turn to other misconduct by the company which they say should be reported to appropriate authorities within a reasonable period, but in any event not more than sixty days after determining there is credible evidence of a violation. Their 98th footnote cites no fewer than eleven different federal authorities as potential recipients of reports depending on the programs at issue , and further includes a passing reference to state authorities as well. Remember that this was in 1998. The current ambiance for expected reporting is certainly heightened over what it was 23 years ago.

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[60] MCG at 70149-50

[61] MCG at 70150

[62] OIG fn 97, MCG at 70151,

The government then turns to the much thornier problem of what happens if the billing company finds that their customer has engaged in misconduct. I have already noted my approach to this potential in the contractual terms I recommend for these relationships,[63] namely that the company should be obligated to bring any concerns to the customer before taking that information anywhere else, including to the government. Here, the government recognizes the "precarious position" of the company in relationship to the customer.[64] The first recommended step where the company finds evidence of misconduct is to refrain from the submission of questionable claims and notify the provider in writing within thirty (30) days of such determination. The notice should include all claim specific information and the rationale for the company's judgment. Interestingly, no further specific action is recommended. Rather "If the billing company discovers credible evidence of the provider's continued misconduct or flagrant fraudulent or abusive conduct"[65], three further steps are recommended: (1) refrain from submitted any false or inappropriate claims; (2) terminate the contract; and (3) report the misconduct to appropriate authorities, but in any event not more than sixty (60) days after determining that there is a credible evidence of a violation. Now that we have the voluntary repayment rules which were not published until 2016[66], juxtapose the company's responsibilities against those of the customer to repay voluntarily amounts which they discover, based on ongoing audit responsibilities. If the customers are performing effectively, the instances in which the billing company would report anything ought to be minimal and likely where the customer simply doesn't understand its independent compliance obligations.

The government sets forth a paragraph regarding reporting procedures, and then moves on to corrective actions. Here the emphasis is on the company's "critical role in the restitution of overpayments to appropriate payors."[67] In the absence, then, of the laws providing the straightforward obligation of providers to repay monies received in error, at least under Medicare, the government appears to have had more faith in the billing company industry than their clients. To make this expectation abundantly clear they said the following: "Failure to notify authorities of an overpayment within a reasonable period of time could be interpreted as an intentional attempt to conceal the overpayment from the Government, thereby establishing an independent basis for a criminal violation *with respect to the billing company,* as well as any individuals who may have been involved."[68] The customer retaining overpayments would only benefit the company if it was paid on a percentage of revenues from claims. This statement essentially casts the billing company in the role of major snitch. The OIG goes on to say that based on this expectation, it behooves the

[63] See 4.1 above.

[64] MCG at 70151

[65] Id

[66] See 4.1 and citations there.

[67] MCG at 70152

[68] Id., Emphasis added

company's compliance program to ensure that overpayments are identified quickly and encourage providers to promptly return overpayments.

7.6 Why It Matters?

So, why so much attention to what the OIG said to billing companies more than twenty years ago? First, given the government's failure to issue up-dates or make any additional changes, the recommendations there remain a foundational guidepost to issues that should be in a billing company's compliance program, which every customer should read before enrolling with them. Second, because as the OIG notes, the essence of the billing company business is to generate claims for their customers, the issues addressed should also be given consideration for inclusion in the physician practice or other provider's own compliance program. The risk analysis suggestions, in particular, are a good basis for crafting a more modern compliance program for any provider, but particularly physician practices. The last reason to pay attention is that these companies can generate investigations and enforcement by the government. If the investigation remains focused exclusively on the company, that is one type of problem; but if the focus includes the practice that is a different problem. Trouble can come in a variety of ways.

8.0 When Things Go Wrong

8.1 Fraud

The numbers and scope of Department of Justice settlements of claims regarding inappropriate billing by providers are litany. Less common is the focus on stand alone billing companies. That said there have been a number of instances where billing companies whose customers were providers entered into settlements of False Claims Act cases. A radiology billing company paid $1.95 million for changing diagnosis codes on radiology claims to get rejected claims paid.[69] In 2015, the DOJ reportedly raided the offices of the largest anesthesia billing company in the country[70], with search warrants and subpoenas, but I could find no further enforcement of them. There is no reported settlement to be found, nor caselaw, nor a Corporate Integrity Agreement.

The billing company sector (or its close consulting company analogues) has become a focus of attention for whistleblowers as well. In *US ex rel Graziosi v, R1 RCM*[71] the whistleblower alleged that the outside consultant had advised its customers to change patient status from observation status, as recommended by the attending physician, to inpatient status which would garner the hospital client more money. The company had advertised its ability to raise hospital revenues by 30-40%; and it was paid on a per claim basis. The court denied

[69] USDOC, "Radiology Billing Company To Pay $1.95 Million To Resolve False Claims Act Allegations" (Oct 14, 2014); https://www.justice.gov/usao-ndga/pr/radiology-billing-company-pay-195-million-resolve-false-claims-act-allegations

[70] MBA Medical, "Anesthesiology Business Consultants Raided by Feds", (July 20, 2015) (https://mbamedical.com/blog/anesthesiology-business-consultants-raided-feds/

[71] 2020 WL 7025082, ED Ill., (Nov 30, 2020)

motions for summary judgment and offered some interesting observations about the applicability of the anti-kickback statute where the company was paid, apparently not for claims reviewed, but only for claims where the coding had been changed.

The government's focus is not only on companies. On October 11, 2018, Tymekka Greenough, the in-house medical biller for First Initiative, LLC , a Nevada behavioral health services provider, agreed to be excluded for a period of *25(!)* years under 42 U.S.C. 1320a-7(b)(7). The OIG's investigation revealed that Greenough knowingly submitted or caused to be submitted claims to the Nevada Medicaid Program on behalf of First Initiative that were false or fraudulent or were not provided as claimed, including: (1) individual psychotherapy services using CPT Codes 90832, 90834, and 90837; (2) individual psychotherapy services utilizing biofeedback training using CPT Code 90876; (3) case management services using CPT Code T1016; and (4) skills training and development services using CPT Code H2014. [72]

In another individual settlement a whistleblower lawsuit had generated settlements with six provider defendants billing to the Department of Labor Office of Worker's Compensation Programs claims for rehabilitation services.[73] The government then turned to the medical biller and her son who had billed for supplies and services not provided, not supported by medical documentation and/or not medically necessary. Most of the patients who had been treated were United States Postal Service employees. Together they had to pay $1.7 million on top of the $3.15 million the billing providers had paid.

Money has not been the sole method of resolving allegations. Very recently the primary insurance biller at a psychology clinic that billed Medicaid for services that were never provided, also billed in family members' names for services never provided to them. Worse yet, the clinic owner paid the biller a 10% commission for all claims paid by Medicaid. The biller was sentenced to 18 months in prison after pleading guilty to one count of conspiracy to commit health care fraud and had to pay $850,000 in restitution.[74] While fraud charges, either from the government or relators, remain relatively unusual, the same can not be said about commercial disputes between companies and their customers.

8.2 Contractual Disputes

Disputes between billing companies and their customers underscore the need to heed my guidance earlier in this article about the content of agreements. In *Darby Anesthesia Associates Inc. v. Anesthesia Business Consultants LLC*[75] the anesthesia group sued the billing

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[72] https://oig.hhs.gov/fraud/enforcement/cmp/cmp-ae.asp

[73] "United States Settles False Claims Act Allegations Against Billing Manger (Agu 28, 2013)https://www.justice.gov/usao-ndca/pr/united-states-settles-false-claims-act-allegations-against-billing-manager

[74] "Insurance Biller Sentenced to 18 Months in Prison for Medicaid Fraud" (Nov 20, 2020) https://www.trussvilletribune.com/2020/11/17/birmingham-woman-pleads-guilty-of-defrauding-alabama-medicaid-agency-of-at-least-1-5-million/

[75] Civ No 06-1656, ED Pa (July 2008)

company after evidence showed the responsible physicians had merely glanced at the contract terms. There were no performance metrics in the document; and the damages were limited to the company's percentage of three months worth of claims revenue, which would have been a little more than $23,000. The practice claimed it lost $300,000 because of the company's failure to submit claims effectively. The practice had the right to review claims but didn't avail themselves of the 90 day right to ask for corrections. They claimed the contract was one of adhesion; and the damages term was unconscionable. The court granted the defendants' partial motion for summary judgement, rejecting all of the plaintiffs' claims.

In another case, noteworthy for the spectacular level of failed performance, a billing company instigated physicians to create a litany and web of other companies to submit claims for inter-operative neuro-monitoring in which the billing company would be a partner. The primary allegations relevant here were that "Of the $190 million the Neuron Shield Enterprise billed for IOM services, MPS collected just $11 million. MPS was unable to collect anything on half of the claims it submitted, and it collected less than one percent of the value on three-quarters."[76] When asked how many other IOM companies she did work for, the primary defendant claimed only one other small company, but in fact had testified elsewhere that she rendered services to 109-110 IOM providers, some of which were competitors of the plaintiff. Because of the convoluted structuring of the entities seeking payment from insurers, the plaintiffs sued for securities fraud, incorporating the marketing representations the defendants had made regarding their skill in collecting on claims as a form of securities fraud. The case had first been filed in 2010. It was not until May, 2019 that the Fifth Circuit reversed the lower court's dismissal on a variety of grounds, finding there had been evidence of fraud that would require evaluation at trial. The case is replete with technical procedural issues, but the representations made in securing the clients proved key when the marketer failed to produce revenue results in any way whatsoever with respect to garnering better payment.

In another Federal Court case[77], the plaintiff home health agency amended its dismissed complaint (with prejudice!) when they had alleged breach of fiduciary duty, to then allege that the billing company breached its agreement by failing to properly submit and monitor patient claims which resulted in their denial. Still further they alleged they suffered more than $7 million in damages from unrecovered claims, lost profits and overhead. The court dismissed both negligence and breach of fiduciary duty claims, but permitted the case to proceed. By 2017, they were still in court fighting over attorneys' fees and more. In another Federal Court case where the plaintiff was the billing company[78], after a four year battle

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[76] *Masel et al v. Villarreal et al,* Fifth Cir Ct. (TX May 15, 2019) No 18-404-99,at 6

[77] *Excellent Home Care Servs. LLC v. FGA Inc.*, (ED NY, Feb 4, 2015) No 1:13-cv-05390-ILG-CLP

[78] *Advanced Reimbursement Solutions, LLC v. Spring Excellence Surgical Hospital,* 2:17-cv-01688, May31, 2017

resulting in a full judgment of $1.7 million against the client who had failed to pay, the parties ultimately settled for an undisclosed amount.[79]

In two Illinois cases involving two separate billing companies, we see how the state prohibition on fee splitting can undermine otherwise relatively straightforward contractual disputes. In *Center for Athletic Medicine Ltd. v. Independent Medical Billers of Illinois Inc.*[80] the plaintiff sports medicine practice sued the billing company alleging they breached their agreement by failing to bill effectively. The plaintiffs claimed damages in excess of $4.4 million. The contract provided for percentage-based payment. Rejecting all the plaintiffs' arguments, including how prevalent percentage-based billing was in the industry and that it did not amount to fee splitting, the court held the lower court was right in dismissing the case because the predicate contract was illegal.

Reversing the facts, in *Kepple and Company Inc v. Cardiac Thoracic and Endovascular Therapies*[81], the billing company sued the practice for breach of contract which contract the lower court found void and unenforceable. The issue here was not the submission of claims, but that the practice had hired from the billing company the woman who had worked their account. There was a no hire clause in the contract with the practice. Upon a motion for summary judgment at the trial court, the judge found completely in favor of the defendants. The plaintiff argued that the fee provision which paid on a percentage was illegal and unenforceable, but that issue was severable from the rest of the agreement which should have been enforced. Looking to the state law on severability, the appellate court found "there can be no dispute that the fee-sharing clause is an essential part of the services contract," which therefore failed in its entirety. The law upon which both cases was based was changed in 2019.[82] That billing companies and their customers end up in contract disputes is apparent. What may be less so are the HIPAA problems companies can create for their customers.

8.3 HIPAA Problems

The final problem area addressed here is HIPAA. The internet abounds with stories of HIPAA data breaches arising out of billing companies. A company in Pennsylvania that serviced hospital-affiliated physician practices notified almost 18,000 patients of a data breach from suspicious activity associated with an employee email account.[83] A ransomware attack on an Iowa based Medicaid billing company compromised up to

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[79] Haaefner, "Texas Surgical Hospital, biller settle four year dispute," (July 30, 2020) https://www.beckershospitalreview.com/finance/texas-surgical-hospital-biller-settle-4-year-dispute.html

[80] IL Ct. of Appeals, First Dist (3d Div), No 1-07-1594 IL (May 28, 2008)

[81] IL Ct of Appeals (3d Dist) No. 3-09-0033 (December 16, 2009)

[82] See n. 24.

[83] "Data breach at a medical billing company potentially exposed the PHI of 18,000 patients", Medicare Web, (December 10, 2019) https://revenuecycleadvisor.com/news-analysis/data-breach-medical-billing-company-potentially-exposed-phi-18000-patients

116,000 patients.[84] At another billing company an individual copied certain items of personal information from the billing system of the University of Pittsburgh Medical Center (UPMC) and then illegally disclosed that information to a third party.[85] And, in a lightning strikes twice horror story, a billing company suffered a ransomware attack, seven months after a computer breach.[86] The breach appeared to have been the basis for the insertion of the ransomware to deploy months later in the hopes of avoiding detection. More than 200,000 patient files were comprised, as reported to the Office for Civil Rights. So, large and small providers are potentially at risk from the maintenance and use of their patients' data by their billing company.

Perhaps the most spectacular breach in the billing company context affected Quest, LabCorp, OpkoHealth and others, potentially compromising data of more than 20 million patients.[87] The stolen data was later advertised for sale in underground web forums. American Medical Collection Agency (AMCA) had a hacker breach its server. When the full extent of the breach was made known, Quest and LabCorp along with AMCA were hit with class action lawsuits charging them all with delay in managing problems they had known about earlier than they had acted.[88] Quest reportedly also sued AMCA in NY, alleging delay in notifying them. Attorneys General in Illinois and Michigan and Senators Booker and Menendez of New Jersey launched investigations. To make matters worse, merely two weeks later, in response to the lawsuits, AMCA filed for bankruptcy under Chapter 11.[89]

Taken together, the risk from failed cybersecurity efforts is significant, both for the companies as well as their customers. The need for robust HIPAA compliance and cybersecurity is paramount in this context. As noted above, close inspection of a company's resources and efforts in this regard is essential for any customer performing due diligence.

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[84] "Ransomware Attack on Medicaid Billing Services provider Impacts 116,000 Individuals", HIPAA Journal (Nov 11, 2020) https://www.hipaajournal.com/ransomware-attack-on-medicaid-billing-service-provider-impacts-116000-individuals/

[85] Snell, "Medical billing company theft leads to potential health data breach", HealthITSecurity (May 18, 2015) https://healthitsecurity.com/news/malware-billing-company-theft-equal-health-data-breaches

[86] "Medical Billing Service Provider Suffers Ransomware Attack 7 Months After Computer Breach," HIPAA Journal (April 26, 2019) https://www.hipaajournal.com/medical-billing-service-provider-suffers-ransomware-attack-7-months-after-computer-breach/

[87] "Cohen, "Third Party Breach Compromises 7.7 million LabCorp Patients' Data," Modern Healthcare (June 5, 2019) https://www.modernhealthcare.com/cybersecurity/third-party-breach-compromises-77-million-labcorp-patients-data; "Opko Health Inc becomes the latest victim of AMCA data breach" (June 7, 2019) https://cyware.com/news/opko-health-inc-becomes-the-latest-victim-of-amca-data-breach-47de3b24

[88] Davis, "Quest, LabCorp, AMCA Face Breach Lawsuits, State Investigations", Health IT Security (June 11, 2019) https://healthitsecurity.com/news/quest-labcorp-amca-face-hit-by-breach-lawsuits-state-investigations

[89] Osborne. "Data breach forces medical debt collector AMCA to file for bankruptcy protection" ZeroDay (June 19, 2019) https://www.zdnet.com/article/medical-debt-collector-amca-files-for-bankruptcy-protection-after-data-breach/

The questions to be posed[90] ought to be just as robust on this score as they ought to be for a billing compliance program.

9.0 Conclusion

The billing company contract sits at the financial heart of a physician practice or any heath care provider enterprise. Without generating revenues effectively, there can be no business. In first year law school we learn that the principal is responsible for the acts of the agent, yet, to date, most providers have barely paid attention to the basics in these agreements, let alone some of the more sophisticated issues I have raised here. Some have suffered the consequences.

The traditional billing company contract is inadequate to today's complex environment. Well run billing companies do not fear any of the provisions I have suggested for inclusion. But the industry will not evolve without market demand. From my perspective, the notion that an accreditation program offered by a well regarded organization evaluating other kinds of electronically-based health care operations got not one customer over seven years[91], speaks to the fact that the market is not demanding enough. It is well beyond time for a revitalization of focus on these utterly fundamental aspects of getting physician practices and other providers paid properly and compliantly.

[90] See 4.1 above for a discussion of relevant contract provisions.

[91] See n. 11, supra.