TO: Mayor and City Council

FROM: Tim Malchow, EMS Chief

SUBJECT: Billing Company

DATE: January 21, 2020

BACKGROUND

The Cannon Falls Ambulance uses a third party for ambulance billing. Talking with other ambulance services and looking at our revenues had me researching billing companies and returns.

Transmedic Billing uses a fee-based for collections and offers a hands-off method to billing. This method allows the experts to assign the billing codes and ensures the documentation matches the billing charge. They will review last year's ambulance billing and determine if any adjustments are needed. Most services that have switched see additional money collected from the previous year.

REQUESTED COUNCIL ACTION

Request a motion to approve the billing agreement and give notice to Expert T Billing we will be ending our contract.

Agreement
Between the City of Cannon Falls and TransMedic Billing

THIS AGREEMENT, made and entered into this 1st day of January, 2020, by and between the City of Cannon Falls, a Minnesota municipal corporation, hereinafter referred to as **"Client,"** and McAlpin Consulting, LLC d/b/a TransMedic Medical Billing Services (TransMedic), whose address is 33 Wentworth Avenue, Suite 380, West Saint Paul, MN, 55118, hereinafter referred to as **"Provider".**

The Client and Provider, in consideration of the mutual terms and conditions, promises, covenants, and payments hereinafter set forth, agree as follows:

SECTION 1: Definitions.

For purposes of this Agreement, the following words and phrases shall have the meanings set forth in this Section, except where the context clearly indicates that a different meaning *is* intended. Any word or term found in this Agreement that is a term of art under the Health Insurance Portability and Accountability Act (HIPAA) shall have the HIPPA definition applied to it.

1. ***Business Associate*** shall mean an entity that performs a function involving the use of disclosure of individually identifiable health information as defined in 45 CFR §160.103. For the purposes of this Agreement, TransMedic shall be considered a Business Associate for the Client.

2. ***Business Records*** shall mean any books, documents, papers, account records and other evidences, whether written, electronic, or in other form, belonging to Provider and pertaining to work performed, under this Agreement.

3. ***Completed Account*** shall mean an ambulance run or medical service provided, where the fees have been invoiced, collected, and deposited in the Clients designated bank account; and where no additional fees are likely to be recovered from any source.

4. ***Covered Entity*** shall mean a health care provider who transmits any health information in electronic form as defined in 45 CFR § 160.103. For purposes of this Agreement, the Client shall be considered a Covered Entity.

5. ***Designated Record Set*** shall have the meaning as defined as 45 CFR Part 164.501.

6. ***EMSRB*** shall mean the Emergency Medical Services Review Board of the State of Minnesota.

7. ***HIPAA*** means the Standards for Privacy of Individually Identifiable Health Information (45 CFR Parts 160 and 164).

8. ***Individual*** means the person who is the subject of the PHI.

9. ***Minimum Necessary*** shall have the meaning as defined in 45 CFR Part 154.502

10. ***Net Dollars Collected*** shall mean the total of daily deposits of paramedic and other medical services fees made to the Clients designated bank account less refunds.

11. ***Privacy Rule*** shall mean the Standards for Privacy of Individually Identifiable Health information as defined in 45 CFR Part 160 and Part 164 Subparts A and E.

12. ***Private Pay*** shall mean a method of paying for the paramedic ambulance and medical services referenced in this Agreement through sources other than reimbursement of fees by insurance companies or governmental programs including but not limited to Medicare.

13. ***Protected Health Information (PHI)*** shall have the same meaning as the term "protected health information" in 45 CFR § 164.501, limited to the information created or received by the Business Associate from or on behalf of a Covered Entity.

14. ***Revenue Recapture Program*** shall mean the municipal ambulance service collection authority and process as defined in Minnesota Statutes § 270A.01 to 270A.12 (the Revenue Recapture Act).

15. ***Ambulance Inter-Governmental Transfer Funding (IGT's)*** shall mean the state program that allows a Governmental ambulance service to leverage a federal match for under payment of Medicaid patients.

16. ***Required By Law*** shall have the same meaning as the term "required by law" in 45 CFR § 164.501.

17. ***Secretary*** means the U. S. Secretary of the Department of Health and Human Services.

18. ***Work product*** shall mean any report, recommendation, paper, presentation, drawing, demonstration, or other materials, whether in written, electronic, or other format that results from Provider's services under this Agreement.

SECTION 2: Scope of Services

A. Provider agrees to provide billing services for the paramedic ambulance and emergency medical services provided by the Client.

B. The specific tasks to be performed are as follows:

1. Obtain all ambulance services data from the Client and review for completeness, accuracy, and correct medical codes needed to perform the billing services. Gather any missing patient information required to

collect service fees and reconcile with the Clients records. The data collection and verification process shall include interacting with receiving hospitals to obtain admitting records and matching with ambulance run records as needed.

2. Verify reimbursement rates and procedures from third party insurance companies, HMOs, Medical Assistance, Medicare, and other related parties. Submit claims to these entities on behalf of the Client.

3. Issue invoices for all paramedic ambulance and medical services provided by the Client, including Extrication and Treat No Transport services, within seven (7) days of receiving complete billing information. Invoices will include, but not be limited to

    a. Medicare claims in the format required for reimbursement;

    b. Claims to HMOs and other insurance companies;

    c. Claims to the patient or other responsible party;

    d. Claims to any other governmental entities or agents; and

    e. Prepare financial information for the Client to file annual IGTs with the Department of Human Services.

4. Take additional steps as may be necessary to collect all fees due and owing for these services. The additional steps may include, but are not limited to, sending reminder letters, interacting with insurance companies, personal contact with the recipients of the services, and referral of accounts to governmental and other assistance programs, such as crime victims or revenue recapture programs.

    If, after taking steps to collect the fees due and owing to the Client on an account, Provider believes that additional efforts will not result in collection of such fees, Provider shall notify the Client about these delinquent accounts as part of its monthly report. This shall include any accounts that have been transmitted to the Revenue Recapture Program, where the customer appears to meet the "hardship" guidelines. The Client shall review the information provided and shall make a final determination about the disposition of the account.

5. Prepare documents for outstanding private pay claims and submit to the State of Minnesota Revenue Recapture Program on behalf of the Client. Accounts to be submitted shall include, but will not be limited to:

    a. Accounts where there is little likelihood of collecting fees due and owing, based on past experience or other information;

b. Accounts that have aged to one hundred and twenty (120) days from the date they were classified as private pay accounts.

Provider shall prepare and transmit a letter to the recipient of the services notifying recipient of the Clients intention to submit the claim to Revenue Recapture. The content and form of the letter shall be approved in advance by the Client. If no payment is received within thirty (30) days of the issuance of this letter, Provider shall transmit the claim with required documentation to the Revenue Recapture Program.

6. Receive, post, and reconcile all fees collected each day for deposit into the designated Client bank account. All money deposited in such account is the sole property of the Client. The Client will grant the Provider view-only electronic access to this account and will arrange for the Provider to receive an electronic copy of the monthly bank statement.

7. Provider shall handle all refunds and provide reports for accounts where duplicate payments have occurred, in accordance with Client procedures.

   a. The Provider will transmit bi-weekly reports to the Client listing each individual account where overpayment has occurred, along with documentation of the original invoice and all payments applied to the account.

   b. Upon receipt and review of the report, the Client will transfer funds to cover the approved refunds into the refund account. Provider will then issue refunds from the account, along with a letter to the recipient of services detailing the reason for the refund.

   c. Provider will include a reconciliation of the refund account for the previous month as part of its standard monthly report to the Client.

   d. The Provider will be responsible for reporting any outstanding refunds to the Client in accordance with the State of Minnesota unclaimed property procedures.

8. By the fifteenth of each month, transmit to the Client, a recap of activity for the previous month. Reports may be submitted electronically, via email. The monthly recap must include the following information at a minimum:

   a. The number and type of service transports billed;

   b. The total number of claims invoiced broken down by category of payer (i.e. Medicare, HMO, insurance, private pay, etc.);

   c. Total dollars billed, broken down by category of payer;

d. A list of all accounts where a cash payment was received by the Provider and deposited into the Clients bank account (including date payment was received and date deposited);

e. A list of the accounts with corresponding amounts owed, sent to Revenue Recapture and the date sent;

f. The total revenue received, summarized by category of payer;

g. A list of all non-cash credits posted;

h. A reconciliation of the monthly bank statement and credits posted listing;

i. A summary of financial activity for the month;

j. An aging schedule for accounts receivable that reflects accounts thirty (30), sixty (60), ninety (90), one hundred and twenty (120), and one hundred and fifty (150) days and over;

k. A list of accounts recommended for hardship status or write-off;

l. A list of refunds to be paid; and

m. A monthly charges and credits summary report.

9. Monitor developments and changes in regulations and circumstances affecting billing and collection services, including changes in the rates of Medicare reimbursements and reporting requirements. Communicate any such changes to the Clients and adapt billing procedures, as directed by the Clients, to conform with the new regulations.

10. Answer calls from recipients of services and others and attempt to resolve any billing or collection problems or questions. Provider shall maintain records of such communication in accordance with the terms of this Agreement and any applicable laws and statutes.

11. As directed by the Client, provide a method for recipients of the paramedic services to pay fees using credit cards, debit cards.

    a. All receipts from credit, debit card payments will be deposited into an account designated by the Client.

    b. The Provider will pay all associated processing and credit card fees.

12. As directed by the Client, assist the Client in submitting ambulance run data into the Minnesota State Ambulance Reporting System (MNSTAR) in accordance with Minnesota Statutes, § 144E.123. At a minimum, the Provider shall enter data elements identified by the EMSRB that are part of the National

Uniform Emergency Medical Services Data set. All ambulance run reports must be entered into MNSTAR within thirty (30) days from the date of the ambulance call. The Client may elect to submit the required information directly into the MNSTAR system electronically and will give the Provider thirty (30) day notice of the date when the manual data entry will no longer need to be performed.

SECTION 3: Contract Period.

The services rendered by the Provider shall be commenced upon execution of the Agreement and continue for one (1) year. The Agreement is automatically renewable on a yearly basis. If either party objects to an upcoming renewal year, that party must provide the objection to the other party in writing, at least ninety (90) days in advance of each renewal date. If there is no objection the Agreement will be automatically renewed under the same terms and conditions.

SECTION 4: Contract Performance.

A. Contacts. The Client has designated the EMS Director within Ambulance service as the manager of this Agreement and the individual to whom all communications pertaining to the Agreement shall be addressed. This contract manager shall have the authority to transmit instructions, receive information, and interpret and define the Clients policies and decisions pertinent to the work covered by this Agreement.

The Client and Provider mutually agree that Brennan "Buck" McAlpin shall serve as the Provider's point of contact for this Agreement.

B. Performance Standards. The Provider will be expected to use industry best practices to maximize the receipt of legitimate third party reimbursement for the paramedic ambulance and emergency medical services and to assist customers in obtaining such reimbursements with a minimum of inconvenience. All services must be performed in accordance with the highest standards of legal ethics and codes of conduct with respect to the collection of debts, communication with debtors and collection procedures made or issued by any governmental agency in any jurisdiction or location in which any attempt to collect the debts described herein is made.

C. Audit. The Provider shall arrange for an annual review and audit of the billing and collection practices and procedures performed pursuant to this Agreement. The audit must be performed by a qualified firm that has no role in the day to day operations of the service provider.

A report describing the results of the audit and an Audited Annual Financial Statement shall be submitted to the Client within four (4) months of the close of the Provider's fiscal year.

SECTION 5: HIPAA Compliance.

A. Obligations and Activities of Provider as a Business Associate. Provider is a Business Associate under the Agreement. Client and Provider mutually agree that Provider shall carry out its obligations under this Agreement in compliance with the Privacy Rule and

shall protect the privacy of any protected health information (PHI) that is collected, processed, or learned as a result of the services provided hereunder:

1. Provider shall not use or disclose PHI except as permitted under this Agreement or by law.

2. Provider will take appropriate steps to safeguard and prevent use or disclosure of PHI except as permitted by this Agreement.

3. Provider agrees to mitigate, to the extent practicable, any harmful effect that is known to Provider of a use or disclosure of PHI by Provider in violation of this Agreement.

4. Provider shall report to the Client any use or disclosure of PHI not provided for by this Agreement of which it becomes aware.

5. Provider shall ensure that any agent including a subcontractor, to whom it provides PHI received from, or created or received by the Provider on behalf of the Client agrees to the same restrictions and conditions that apply through this Agreement to Provider with respect to such information.

6. Provider agrees to provide access, at the request of the Client, and in the time and manner mutually agreed upon with the Client, to make PHI available to the Client or as directed by the Client to an Individual to meet the requirements under 45 CFR§ 164.524.

7. Provider agrees to make its internal practices, books, and records, including policies and procedures, relating to the use and disclosures of PHI received from, or created or received by the Provider on behalf of, the Client, available to the Secretary for purposes of determining the Client compliance with HIPAA.

8. Provider agrees to document such disclosures of PHI and information related to such disclosures as would be required for the Client to respond to a request by an Individual for an accounting of disclosures of PHI in accordance with 45 CFR § 164.528.

B. Permitted Uses and Disclosures. 'Except as otherwise permitted under this Agreement, Provider may only use or disclose PHI to the Client and other Clients identified Provider contractors in, order to provide services to the Client for the following purposes, if such use or disclosure of PHI would not violate the Privacy Rule if done by the Client or HIPAA "minimum necessary" policies and procedures of the Client.

1. Preparation of invoices to the Individuals, treatment, payment, or health care operations or otherwise required by HIPAA.

2. Preparation of reminder notices and documents pertaining to collection of overdue Accounts to the Individuals, treatment, payment, or health care operations or otherwise required by HIPAA.

3. Submission of supporting documentation to the Individuals, treatment, payment, or health care operations or otherwise required by HIPAA to substantiate the health care services provided by the Client to its patients or to appeal denial of payment for the same.

4. Other uses or disclosures of PHI as permitted by the Privacy Rule.

C. Obligations of the Client.

1. The Client shall notify the Provider of any limitation(s) in its notice of privacy practices of the Client in accordance with 45 CFR § 164.520, to the extent that such limitation may affect Provider's use or disclosure of PHI.

2. The Client shall notify the Provider of any changes in, or revocation of, permission by an Individual to use or disclosure PHI, to the extent that such changes may affect Provider's use or disclosure of PHI.

3. The Client shall notify the Provider of any restriction to the use or disclosure of PHI that the Client has agreed to in accordance with 45 CFR § 164.522, to the extent that such changes may affect Business Associate's use or disclosure of PHI.

SECTION 6: Billings and Payment.

A. That for Provider's faithful performance of this Agreement, the City of Cannon Falls Ambulance Service hereby agrees to compensate the Provider at a rate of fifteen dollars ($15) per account entered into the billing system in the month recently completed plus 2.00% of net dollars collected in that month.
B. Client accounts prior to Transmedic assuming billing services shall be collected at the same fee structure

C. The above amounts shall fully compensate the Provider for all costs. No claim for services and/or costs provided by the Provider, not specifically provided for in the Agreement will be honored by the Client.

D. Provider shall submit a monthly invoice to the Client. The invoice shall state the number of completed transactions and the net dollars used to calculate the fee. Provider shall also state the number of transport and non-transport accounts entered into the MNStar System. Upon receipt of the invoice and verification of the charges, payment shall be made by the Client to Provider within thirty (30) days.

SECTION 7: Termination.

A. This Agreement will continue in full force and effect for the term specified in SECTION 3.

B. In the event of termination, the Client will pay Provider for all services actually, timely, and faithfully rendered up to the receipt of the notice of termination and thereafter until the date of termination. The Provider will deliver all work products and supporting documentation developed up to the date of termination prior to the Client rendering final payment for service.

C. Notwithstanding any other provisions of this Agreement, this Agreement may be terminated by the Client, in its sole discretion, if the Client determines that Provider has violated a term or provision of the Agreement pertaining to the Clients' obligations under the HIPAA privacy rule.

D. Upon termination of this Agreement, for any reason, as directed by the Client, Provider shall return all Protected Health Information received from the Client or created or received by the Provider on behalf of the Client. This provision shall apply to PHI that is in the possession of subcontractors or agents of the Provider. Provider shall retain no copies of the Protected Health Information.

E. In the event that the Provider determines that returning or destroying the PHI is infeasible, Provider shall provide the Client notification of the conditions that make the return or destruction infeasible. After Client's review and acceptance of Business Associate's notification of conditions of infeasibility, Provider shall extend HIPAA protections of this Agreement to such PHI for so long as the Provider possesses in any form such PHI, at no cost to the Client.

F. With Cause — The Client reserves the right to suspend or terminate this Agreement if the Provider violates any of the terms or conditions of this Agreement or does not fulfill, in a timely and proper manner, its obligations under this Agreement as determined by the Client. In the event that the Client exercises its right to withhold payment or terminate under this Section, it shall submit written notice to the Provider, specifying the extent of such withholding or termination under this Section, the reasons therefore, and the date upon which such withholding or termination becomes effective. Upon receipt of such notice, the Provider shall take all actions necessary to discontinue further commitments of funds to the extent that they relate to the suspended or terminated portions of this Agreement.

SECTION 8: Miscellaneous.

A. Amendment. The parties agree to amend this Agreement from time to time as is necessary for the Client to comply with the requirements of the Privacy Rule and the Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191.

B. Interpretation. Any ambiguity in this Agreement shall be resolved to permit the Client to comply with the Privacy Act.

C. Regulatory References. A reference in this Agreement to a section in HIPAA means the section as in effect or as amended.

SECTION 9: Work Products, Records, Dissemination of Information.

A. All deliverable work products and supporting documentation that result from the Provider's services under this Agreement shall be delivered to the Client and shall become the property of the Client after final payment is made to the Provider with not right, title, or interest in said work products or supporting documentation vesting in Provider.

B. In the event of termination, all work products, whether finished or unfinished, and supporting documentation prepared by the Provider under this Agreement shall be delivered by Provider to the Client by the termination date and there shall be no further obligation of the Client to Provider except for payment of amounts due and owing for any authorized work performed and expenses incurred to the date and time of termination.

C. Provider agrees to maintain all business records in such a manner as will readily conform to the terms of this Agreement and to make such records available at its office at all reasonable times during the Agreement period and for six (6) years from the date of the final payment under the contract for inspection or audit by the Client, the State Auditor, or other duly authorized representative.

D. Provider agrees to abide strictly by Chapter 13 of the Minnesota Statutes (Minnesota Government Data Practice Act) as well as any other applicable federal, state, and local laws or ordinances, and all applicable rules, regulations, and standards established by any agency of such governmental units which are now or hereafter promulgated insofar as they related to the Provider's performance of the provisions of this Agreement. All of the data created, collected, received, stored, used, maintained, or disseminated by the Provider is subject to the requirements of Chapter 13 and the Provider must comply with these requirements as if it were a governmental entity. The remedies in Section 13.08 apply to the Provider.

SECTION 10: Compliance with Applicable Law.

Provider agrees to comply with all federal, state, and local laws or ordinances, and all applicable rules, regulations, and standards established by any agency of such governmental units, which are now or hereafter promulgated insofar as they relate to the Provider's performance of the provisions of this Agreement. It shall be the obligation of the Provider to apply for, pay for, and obtain all permits and/or licenses required.

SECTION 11: Conflict of Interest.

A. Provider will not contract for or accept employment for the performance of any work or services with any individual, business, corporation, or governmental unit that would create a conflict of interest in the performance of the obligations pursuant to this Agreement with the Client.

B. Provider agrees that should any conflict or potential conflict of interest becomes known; Provider will advise the Contract Manager of the situation so that a determination can be made about the Provider's ability to continue performing services under the Agreement.

SECTION 12: Insurance and Bonds.

Provider shall be required to carry insurance of the kind and in the amounts shown below for the life of the contract. Insurance certificates should state that the Client, its officials, employees, agents and representatives are named as Additional Insureds.

1. General or Business Liability Insurance

a.	Bodily Injury	$1,500,000	each occurrence
		$2,500,000	aggregate
b.	Property Damage	$1,500,000	each occurrence
		$2,500,000	aggregate

c. Policy must include an "all services, products, or completed operations" endorsement.

2. General Insurance Requirements

a. The policy is to be written on an occurrence basis or as acceptable to the Client. Certificate of Insurance must indicate if the policy is issued on a claims-made or occurrence basis. All certificates of insurance shall provide that the Client be given not less than thirty (30) days prior written notice of cancellation, non-renewal or any material changes in the policy, including but not limited to, coverage amounts. Agent must state on the certificate if policy includes errors and omissions coverage.

b. Workers Compensation Coverage for Transmedic Employees

c. The Client reserves the right to review Provider's insurance policies at any time, to verify that the Client requirements have been met.

SECTION 13: Independent Contractor.

It is agreed by the parties that, at all times and for all purposes within the scope of this Agreement, the relationship of the Provider to the Client is that of independent contractor and not that of employee. No statement contained in this Agreement shall be construed so as to find Provider an employee of the Client, and Provider shall be entitled to none of the rights, privileges, or benefits of Client employees.

SECTION 14: Hold Harmless.

The Provider shall indemnify, save, hold harmless, protect, and defend the Client, its officers, agents, and employees for all claims, actions or suits of any character brought for or on account of any claimed or alleged injuries or damages received by any person or property, including the Client resulting from any negligent act or omission by any person employed by Provider in carrying out the terms of this Agreement.

SECTION 15: Assignment.

The Client and Provider each binds itself and its successors, legal representatives, and assigns of such other party, with respect to all covenant of this Agreement; and neither the Client not the Provider will assign or transfer their interest in this Agreement without the written consent of the other.

SECTION 16: Notices.

Except as otherwise state in this Agreement, any notice or demand to be given under this Agreement shall be delivered in person or deposited in United States Certified Mail, Return Receipt Requested. Any notices or other communications shall be addressed as follows:

To Client:
Cannon Falls Ambulance
Attn: EMS Director
322 Hoffman Street West
Cannon Falls, MN 55009

To Provider:
TransMedic Billing
Attn: Buck McAlpin
33 Wentworth Avenue, Suite 380
West Saint Paul, MN 55118

SECTION 17: Waiver.

Any failure of a party to assert any right under this Agreement shall not constitute a waiver or a termination of that right, this Agreement, or any of this Agreement's provisions.

SECTION 18: Interpretation of Agreement, Venue.

This Agreement shall be interpreted and construed according to the laws of the State of Minnesota. All litigation related to this Agreement shall be venued in the District Court of the County of Goodhue, First Judicial District, State of Minnesota.

SECTION 19: Force Majeure.

Neither the Client nor Provider shall be held responsible for performance if its performance is prevented by acts or events beyond the party's reasonable control including, but not limited to severe weather and storms, earthquake or other natural occurrences, strikes and other labor unrest, power failures electrical power surges or current fluctuations, nuclear or other civil military emergencies, or acts of legislative, judicial, executive, or administrative authorities.

SECTION 20: Entire Agreement.

It is understood and agreed that this entire Agreement supersedes all oral agreements and negotiations between the parties relating to the subject matters herein.

IN WITNESS WHEREOF, the parties hereto are authorized signatories and have executed this Agreement, the day and year first above written.

For the City of Cannon Falls:

By: _____

Its: _____

For TransMedic Billing:

By: _____

Its: _____

Taxpayer ID: 41-1834731