



RESOLUTION: 29(20)

SUBMITTED BY: Robert McNamara, MD
Thomas Scaletta, MD, FACEP

SUBJECT: Billing and Collections Transparency in Emergency Medicine

PURPOSE: 1) Amend two current ACEP policy statement to stipulate a requirement that all members shall automatically receive monthly detailed reports of services billed in their names. 2) Adopt a new policy statement prohibiting members from denying another emergency physician access to monthly detailed information about billing and collections for their services. 3) Petition state or federal legislative and regulatory to require revenue cycle management entities to provide every emergency physician it bills or collects for with a detailed itemized statement of billing and remittances for medical services they provide on at least a monthly basis. 4) Adopt a new policy statement prohibiting any entity that fails to meet this standard from advertising, exhibiting, sponsoring, or otherwise being associated with ACEP.

FISCAL IMPACT: Budgeted committee and staff resources for policy development and advocacy efforts. Potentially significant reduction in outside funding support.

1 WHEREAS, It is common knowledge that many ACEP members are denied access to what is billed and
2 collected in their name; and
3

4 WHEREAS, A lack of transparency regarding what is billed and collected in a physician’s name breeds
5 distrust and can lead to a feeling of being exploited and cause additional dissatisfaction for those practicing the
6 difficult specialty of emergency medicine; and
7

8 WHEREAS, Without transparency regarding what is billed and collected in a physician’s name the efforts to
9 end gender disparity in physician pay will be lacking due to insufficient information; and
10

11 WHEREAS, The physician is supposed to see this information to ensure honest billings and can be held
12 individually liable for up coding and fraud; and
13

14 WHEREAS, Without this information the physician risks being a party to fee-splitting whereby a physician
15 gives up a portion of their professional fee above fair market value in return for the right to see patients (receive
16 referrals) in the ED; and
17

18 WHEREAS, The original Bylaws of ACEP opposed fee-splitting stating that “In the practice of medicine, a
19 physician shall limit the source of his income to medical services actually rendered by him to his patients. He should
20 neither pay nor receive a commission for referral of patients.”; and
21

22 WHEREAS, Participation in prohibited fee splitting has long been recognized as a risk to the emergency
23 physician by ACEP as demonstrated in the 1996 book published by ACEP written by Kalifon and Sullivan titled
24 “Before you sign. Contract basics for the emergency physician” and this book states “Medicare, Medicaid and some
25 states’ laws prohibit kickbacks and fee-splitting. The Group and the Contractor (the physician) might violate these
26 laws if the Group retains or, phrased differently, the Contractor pays more than fair market value for the services the
27 Group provides to the Contractor.”; and
28

29 WHEREAS, With reports of fee-splitting being up to 20% of the professional fee this is a significant
30 economic issue for the membership of the ACEP, the value of which could run in the millions over a 20- to 30-year
31 career; and

32 WHEREAS, AMA policy H – 190.971 states that “all physicians are entitled to receive detailed itemized
33 billing and remittance information for medical services they provide, and that our AMA develop strategies to assist
34 physicians who are denied such information” (reaffirmed 2017); and
35

36 WHEREAS, The FTC in 2004 (8/30/04 letter of Jeffery W. Brennan to Alvin Dunn, Esq.) stated in response
37 to antitrust concerns raised by ACEP, that ACEP could respond to “behavior of market participants that it believes are
38 detrimental to its members or the public”; and
39

40 WHEREAS, Denial of this information can be detrimental to ACEP members in regard to unwitting
41 participation in fee-splitting and upcoding as well as to the public if they are subject to excessive charges; and
42

43 WHEREAS, The billing entity is supposed to be answerable to the individual physician; and
44

45 WHEREAS, The reputation of an emergency physician can be affected if inflated bills for services are sent to
46 the patient; therefore be it
47

48 RESOLVED, That ACEP modify the existing policy statement “Emergency Physician Contractual
49 Relationships” through deletion and substitution as follows: “The emergency physician ~~should~~ **shall receive detailed**
50 **itemized reports on** ~~have the right to review~~ what is billed and collected for his or her service **on at least a monthly**
51 **basis** regardless of whether or not billing and collection is assigned to another entity within the limits of state and
52 federal law. **The emergency physician shall not be asked to waive access to this information.**”; and be it further
53

54 RESOLVED, That ACEP modify the existing policy statement “Emergency Physician Rights and
55 Responsibilities” through deletion and substitution as follows: “5. Emergency physicians ~~should~~ **shall** be provided
56 ~~periodic~~ **detailed itemized** reports of billings and collections in their name **on at least a monthly basis** and have the
57 right to audit such billings, without retribution. **The emergency physician shall not be asked to waive access to this**
58 **information.**”; and be it further
59

60 RESOLVED, That ACEP adopt as policy that: “No member of ACEP will, directly or indirectly, deny
61 another emergency physician the ability to receive detailed itemized billing and remittance information for medical
62 services they provide.”; and be it further
63

64 RESOLVED, That ACEP petition the appropriate state or federal legislative and regulatory bodies to
65 establish the requirement that revenue cycle management entities, regardless of their ownership structure, will directly
66 provide every emergency physician it bills or collects for with a detailed itemized statement of billing and remittances
67 for medical services they provide on at least a monthly basis; and be it further
68

69 RESOLVED, That ACEP adopt this policy: “Any entity that wishes to advertise in ACEP vehicles, exhibit at
70 its meetings, provide sponsorship, other support or otherwise be associated with ACEP will as of January 1, 2021,
71 provide every emergency physician associated with that entity, at a minimum, a monthly statement with detailed
72 information on what has been billed and collected in the physician’s name. This information must be provided without
73 the need for the physician to request it. Physicians cannot be asked to waive access to this information. The entities
74 affected include but is not limited to revenue cycle management companies, physician groups, hospitals, and staffing
75 companies.”

Background

This resolution directs ACEP to amend two current policy statements, “Emergency Physicians Contractual Relationships” and “Emergency Physician Rights and Responsibilities,” to stipulate a requirement that all members shall automatically receive monthly detailed reports of services billed in their names. The resolution further directs ACEP to adopt a new policy statement prohibiting members from denying another emergency physician access to monthly detailed information about billing and collections for their services. Additionally, the resolution directs ACEP to petition state and federal regulatory bodies to require revenue cycle management entities, regardless of their

ownership structure, to provide every emergency physician it bills or collects for with a detailed itemized statement of billing and remittances for medical services they provide on at least a monthly basis. Finally, the resolution directs ACEP to adopt a new policy statement prohibiting any entity that fails to meet this standard from advertising, exhibiting, sponsoring, or otherwise being associated with ACEP and that these reports should be provided automatically to every member without a requirement to request such reports.

The intent of this resolution is similar to Resolution 30(20) Protection and Transparency, therefore the background for both resolutions is also similar. The scope of Resolution 30(20) is not as comprehensive.

The requested new policy stating that “no member of ACEP will, directly or indirectly, deny another emergency physician the ability to receive detailed itemized billing and remittance information for medical services they provide” would presumably be enforced through ACEP’s ethics procedures. Non-member entities would not be subject to this process for member violations.

ACEP’s policy statement “[Emergency Physician Contractual Relationships](#)” and the associated [Policy Resource and Education Paper](#) (PREP) convey support for the rights of an emergency physician to review what is billed and collected in their name. Further, the PREP states that “the contracting parties should be ethically bound to honor the terms of any contractual agreement to which it is party and to relate to one another in an ethical manner.”

Although patients are generally billed on behalf of the specific emergency physician who cared for them, the way business is structured in emergency medicine, funds paid by a patient or by a third-party payer on behalf of a patient do not generally go directly to the emergency physician. In most instances, the emergency physician has assigned his or her payments to another entity, generally the entity contracted with the emergency physician. The physician, however, is responsible for the accuracy of the charting and also the accuracy of the coding and billing based upon the physician’s charting. The bottom of the Health Insurance Claim Form 1500 (required by many government payers) reads:

SIGNATURE OF PHYSICIAN (OR SUPPLIER): I certify that the services listed above were medically indicated and necessary to the health of this patient and were personally furnished by me or my employee under my personal direction.

NOTICE: This is to certify that the foregoing information is true, accurate and complete. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws.”

Like many professional associations, ACEP provides venues for competitors to communicate with its members such as exhibiting at meetings, sponsoring events, and advertising in publications. While some court decisions allow associations to offer or deny access to these venues on arbitrary grounds, there is also case law holding that a denial of essential means of competition may be made the basis for antitrust challenges against associations. Since ACEP is the oldest and largest association of emergency physicians and its *Scientific Assembly* is the largest emergency medicine meeting in the world, excluding certain competitors from these venues could have a significant, adverse impact on those competitors’ ability to compete and could result in antitrust litigation filed against ACEP.

ACEP’s “[Antitrust](#)” policy statement states: “The College is not organized to and may not play any role in the competitive decisions of its member or their employees, nor in any way restrict competition among members or potential members. Rather it serves as a forum for a free and open discussion of diverse opinions without in any way attempting to encourage or sanction any particular business practice.” The policy further specifies:

- There will be no discussions discouraging or withholding patronage or services from, or encouraging exclusive dealing with any health care provider or group of health care providers...
- There will be no discussions about restricting, limiting, prohibiting, or sanctioning advertising or solicitation that is not false, misleading, deceptive, or directly competitive with College products or services.
- There will be no discussions about discouraging entry into or competition in any segment of the health care market.

- There will be no discussions about whether the practices of any member, actual or potential competitor, or other person are unethical or anti-competitive, unless the discussions or complaints follow the prescribed due process provisions of the College's bylaws.

Adoption of a policy that prohibits members from denying other emergency physicians the right to detailed reports of billing and collections for their services would presumably mean that members could face sanctions, including possible expulsion from membership, for failing to abide by the policy. ACEP would be required to report any suspension or expulsion to the National Practitioners Data Bank. Enforcement of self-regulation codes, even if the enforcement is not anti-competitive, must be carried out in a manner that affords the alleged offender due process, which includes proper notice and a fair hearing. The ACEP Bylaws state that “Members of the College may be subject to disciplinary action or their membership may be suspended or terminated by the Board of Directors for good cause. Procedures for such disciplinary action shall be stated in the College Manual.” The College Manual currently describes the process for addressing all disciplinary actions and is the process currently used to adjudicate ethics charges.

Should the resolution be adopted, the College would be required to create and implement a means of investigating alleged offenses, responding to complaints of noncompliance, gathering evidence, and conducting fair and impartial hearings to provide adequate due process to the accused member(s). The College would also be required to impose a similar process to determine whether it should refuse or accept advertising, sponsorship, or offer to exhibit from an individual or group. It is possible that the filing of charges and the conduct of this process could be used as a tool by competitors to discredit or limit the effectiveness of their competition.

Taking enforcement action to revoke a member's membership or deny an entity's ability to exhibit, sponsor, or advertise with ACEP may create additional potential liability risk for ACEP. Affected members could bring legal action against the College with claims of defamation, limiting professional opportunities, or denial of due process on the part of ACEP. Excluding an entity from being able to sponsor any ACEP activity could subject the College to a claim of restraint of trade. Such challenges can be mitigated by developing and adhering to strict processes.

Currently, approximately 24% of all corporate support in FY 2019-20 was derived from physician groups, staffing companies, and hospitals/clinics. Combined, they contributed \$1,055,000 in advertising, exhibits, and all other sponsorship of ACEP programs and activities.

ACEP Strategic Plan Reference

Goal 1 – Improve the Delivery System for Acute Care

Objective E: Pursue strategies for fair payment and practice sustainability to ensure patient access to care.

Fiscal Impact

Budgeted committee and staff resources for policy development and advocacy efforts. The financial impact would depend on how many entities would not agree to provide monthly detailed itemized reports to all contracted emergency physicians. Physician groups, staffing companies, and hospitals/clinics contributed \$1,055,000 in advertising, exhibits, and all other sponsorship of ACEP programs and activities in FY 2019-20. Additionally, ACEP's prescribed procedures for adjudicating accusations of member misconduct is time intensive for the Ethics Committee, Board of Directors, and staff involved in investigation and rendering decisions on ethics complaints.

Prior Council Action

Resolution 15(02) Promotion of College Policies on Contracting and Compensation not adopted. Requested the Board of Directors to review the policy statement “Promotion of College Policies on Contracting and Compensation” and potentially realign it with other ACEP policies or rescind it and report back to the 2003 Council.

Resolution 14(02) Emergency Physician Rights and Self-Disclosure not adopted. The resolution would have required any exhibitor, advertiser, grant provider, and sponsor who employs emergency physicians as medical care providers to

disclose their level of compliance with College policies on compensation and contractual relationships.

Amended Resolution 14(01) Fair and Equitable EM Practice Environments adopted. Directed ACEP to continue to study the issue of contract management groups and determine what steps should be taken by ACEP to more strongly encourage a fair and equitable practice environment and to continue to promote the adoption of the principles outlined in the “Emergency Physician Rights and Responsibilities” policy statement by the various emergency medicine contract management groups, the American Hospital Association and other pertinent organizations.

Resolution 12(01) Coercive Contracting not adopted. Directed ACEP to discourage any contracting practice that may be illegal, unethical, or any practice that may circumvent fair and equitable negotiations and to explore legal issues surrounding coercive contracting and if appropriate request an OIG opinion on contracts that force emergency physicians to accept less than fair market value reimbursement from third party payers in exchange for the right to retain their contract.

Substitute Resolution 10(01) Commercial Sponsorships adopted. Directed the Board to continue initiatives to develop and implement policies on self-disclosure of compliance by sponsors, grant providers, advertisers, and exhibitors at ACEP meetings with ACEP physicians’ rights policies, including: “Emergency Physicians Rights and Responsibilities,” “Emergency Physician Contractual Relationships,” “Agreements Restricting the Practice of Emergency Medicine,” and “Compensation Arrangements for Emergency Physicians”

Amended Resolution 20(00) Due Process in Contracts Between Physicians and Hospitals, Health Systems, and Contract Groups adopted. Directed ACEP to endorse the right to have due process provisions in contracts between physicians and hospitals, health systems, health plans, and contract groups.

Amended Resolution 74(95) Support Part B of the Health Care Quality Improvement Act not adopted. There were concerns about anti-kickback statutes and the need to recognize where it occurs between both hospitals and contracting entities and management companies and physicians.

Substitute Resolution 56(94) Exploitation of Emergency Physicians adopted. Called for ACEP to reaffirm its value statement that “the best interests of the patient are served when emergency physicians practice in a fair, equitable, and supportive environment,” and its accompanying objective that “fair and equitable compensation for emergency physicians will be established through fair business practices and be available for all emergency services rendered.”

Amended Resolution 49(94) Information on Contract Issues adopted. Directed ACEP to continue efforts to provide members with current and comprehensive information to assist them in negotiating contracts.

Substitute Resolution 9(93) Contractual Relationships adopted. Called for ACEP to support fair and equitable contractual business arrangements and promote these relationships through a public relations campaign and the development of a policy statement on fair and equitable contractual relationships.

Substitute Resolution 18(85) Fairness adopted. Directed the development of a position statement on contractual relationships between emergency physicians and contracting/employing entities that addresses emergency physicians’ rights to fair and equitable treatment.

Prior Board Action

January 2019, reaffirmed the policy statement “[Antitrust](#),” reaffirmed June 2013 and October 2007; revised and approved October 2001; originally approved June 1996 replacing a policy statement with the same title that was approved in April 1994.

July 2018, reviewed the Policy Resource & Education Paper (PREP) “[Emergency Physician Contractual Relationships](#)” as an adjunct to the policy statement “Emergency Physician Contractual Relationships.”

June 2018, approved the revised policy statement “[Emergency Physician Contractual Relationships](#),” revised and approved October 2012, January 2006, March 1999, and August 1993 with the current title. Originally approved

October 1984 titled “Contractual Relationships between Emergency Physicians and Hospitals.”

January 2017 approved the revised policy statement “[Code of Ethics for Emergency Physicians;](#)” revised and approved June 2016 and June 2008; reaffirmed October 2001; revised and approved June 1997 with the current title; originally approved January 1991 titled “Ethics Manual.”

October 2015, approved the revised policy statement “[Emergency Physician Rights and Responsibilities;](#)” revised and approved April 2008 and July 2001; originally approved September 2000.

April 2015, approved the revised policy statement “[Compensation Arrangements for Emergency Physicians;](#)” revised and approved April 2002 and June 1997; reaffirmed October 2008 and April 1982; originally approved June 1988.

Amended Resolution 14(01) Fair and Equitable Emergency Medicine Practice Environments adopted.

Substitute Resolution 10(01) Commercial Sponsorships adopted.

Amended Resolution 20(00) Due Process in Contracts Between Physicians and Hospitals, Health Systems, and Contract Groups adopted.

June 1997 reviewed the information paper “Fairness Issues and Due Process Considerations in Various Emergency Physician Relationships.”

Substitute Resolution 56(94) Exploitation of Emergency Physicians adopted.

Amended Resolution 49(94) Information on Contract Issues adopted.

Substitute Resolution 9(93) Contractual Relationships adopted. A Contracts Task Force was appointed as a result of this resolution.

Substitute Resolution 18(85) Fairness adopted.

Background Information Prepared by: David McKenzie, CAE
Reimbursement Director

Adam Krushinskie, MPA
Reimbursement Manager

Reviewed by: Gary Katz, MD, MBA, FACEP, Speaker
Kelly Gray-Eurom, MD, MMM, FACEP, Vice Speaker
Susan Sedory, MA, CAE, Council Secretary and Executive Director