FOR U.S. SKILLED NURSING AND ASSISTED LIVING OPERATORS

# The Billing Contract Checklist

What to confirm in a nursing home medical billing service agreement before you sign: scope, federal deadlines, fees, KPIs, compliance and exit.

## How to use it

Work through the draft agreement section by section, in the order below.
Tick each item once the draft covers it, and note what needs to change.
Give each section to the right reviewer: CFO for fees and KPIs, compliance for data and audits, administrator for scope and service levels, owner for exit.
Start with the items marked Must have, then work through the rest.
Bring your notes to the negotiation, and to your counsel for the final read.

# Before you start

A billing service agreement decides who carries the risk when work stalls. In the median U.S. skilled nursing facility, Medicaid pays for most resident days, according to MedPAC, and Medicare Advantage now covers more than half of eligible Medicare beneficiaries, according to KFF, so the hardest billing work sits in eligibility, liability, authorizations and follow-up rather than claim submission alone. Use this checklist to confirm that your draft agreement names that work, times it against federal deadlines, prices it clearly and lets you leave with your records. Items marked Must have protect cash, compliance or your exit, so hold firm on them. Items marked Negotiate are worth asking for, but can be traded.

| | |
|---|---|
| **Facility or group** | |
| **Vendor** | |
| **Draft version and date** | |
| **Reviewed by** | |

## 1 SCOPE OF SERVICES, BY PAYER

Anything the schedule doesn't name sits outside the fee.

| | PRIORITY | CONFIRM IN THE DRAFT | WHAT IT SAYS NOW, OR WHAT TO ASK FOR |
|---|---|---|---|
| ☐ | **Must have** | A signed scope schedule names each facility, payer, task, deliverable, start date and who supplies the information. | |
| ☐ | **Must have** | Medicare Part A and Part B work is listed, including returned claims, consolidated billing questions, coinsurance, crossovers and bad debt documentation. | |
| ☐ | **Must have** | Medicare Advantage scope says whether it covers claims only, or also authorizations, concurrent reviews, records requests and appeals. | |
| ☐ | **Must have** | Each state Medicaid program and managed care plan is named, with pending eligibility and patient liability stated as in or out. | |
| ☐ | Negotiate | Private pay statements, follow-up and who speaks with families are assigned. | |
| ☐ | Negotiate | Resident trust fund work is stated as included, contracted separately or excluded. | |
| ☐ | **Must have** | Credit balances, rebills, audit requests, appeals and pre-contract balances are covered. | |

| | PRIORITY | CONFIRM IN THE DRAFT | WHAT IT SAYS NOW, OR WHAT TO ASK FOR |
|---|---|---|---|
| ☐ | **Must have** | The line between clinical work (assessments, documentation, triple check sign-off) and billing work is written down. | |
| ☐ | Negotiate | Handoffs for payer records requests name who receives, gathers and sends the records. | |

## 2 ASSISTED LIVING COMMUNITIES

ALF billing runs on different rules, so give it its own schedule.

| | PRIORITY | CONFIRM IN THE DRAFT | WHAT IT SAYS NOW, OR WHAT TO ASK FOR |
|---|---|---|---|
| ☐ | **Must have** | ALF work sits in a separate schedule, with no SNF Medicare Part A duties carried over by default. | |
| ☐ | **Must have** | Private pay billing, move-in charges, level-of-care changes and resident statements are assigned. | |
| ☐ | **Must have** | Any state Medicaid waiver or HCBS billing is named by state program, with eligibility and authorization steps assigned. | |
| ☐ | Negotiate | Family communication, deposits and refunds on move-out have a named owner. | |

## 3 REGULATORY CLOCKS AND SERVICE LEVELS

Each vendor deadline should fall well inside the federal one.

| | PRIORITY | CONFIRM IN THE DRAFT | WHAT IT SAYS NOW, OR WHAT TO ASK FOR |
|---|---|---|---|
| ☐ | **Must have** | Claims go out on a schedule far shorter than the one-year Medicare filing limit (42 CFR 424.44), and held claims are escalated. | |
| ☐ | **Must have** | The vendor tells you about a suspected overpayment within a set number of business days, leaving time for the 60-day rule and any good-faith investigation (42 CFR 401.305). | |
| ☐ | **Must have** | Security incident escalation is much shorter than the 60-day business associate breach limit (45 CFR 164.410). | |
| ☐ | **Must have** | Documentation requests are routed immediately, with named record owners and an internal deadline before the 45-day (or 30-day UPIC) limit. | |

| | PRIORITY | CONFIRM IN THE DRAFT | WHAT IT SAYS NOW, OR WHAT TO ASK FOR |
|---|---|---|---|
| ☐ | Negotiate | The vendor supplies billing agency details for your CMS-855A update at signing and at exit (90 days, 42 CFR 424.516). | |
| ☐ | Negotiate | If authorizations are in scope, submissions, payer responses, denial reasons and review dates are logged (CMS-0057-F timelines). | |
| ☐ | **Must have** | Denial turnaround is set in business days, with a precise start event. | |
| ☐ | **Must have** | Cash posting lag is set in business days, with a precise start event. | |
| ☐ | **Must have** | An exception log keeps every held claim visible with amount, reason, owner and next follow-up date. | |

## 4 FEES AND INCENTIVES

The fee decides which work gets rewarded.

| | PRIORITY | CONFIRM IN THE DRAFT | WHAT IT SAYS NOW, OR WHAT TO ASK FOR |
|---|---|---|---|
| ☐ | **Must have** | Collections is defined: patient liability your staff collect, pre-contract claims, retroactive Medicaid, unworked receipts, refunds and recoupments. | |
| ☐ | **Must have** | Legacy AR is priced: base fee, runout rate or a separate cleanup project. | |
| ☐ | Negotiate | The fee model (fixed, percentage or hybrid) matches the work, including slow eligibility follow-up. | |
| ☐ | **Must have** | Every other charge is listed, from implementation and software to data exports, termination and runout. | |
| ☐ | Negotiate | Annual price increases are capped and tied to a stated index or percentage. | |
| ☐ | **Must have** | If the vendor would ever receive Medicare payments for you, counsel has reviewed the agent payment conditions (42 CFR 424.73). | |
| ☐ | Negotiate | Each vendor has priced the same three ledger entries: an old-AR recovery, a retroactive Medicaid payment and a recoupment. | |

## 5 PERFORMANCE GUARANTEES AND LIABILITY

Guarantee what the vendor controls. Review the rest together.

| | PRIORITY | CONFIRM IN THE DRAFT | WHAT IT SAYS NOW, OR WHAT TO ASK FOR |
|---|---|---|---|
| ☐ | **Must have** | Guarantees cover vendor-controlled work (claims, rejections, escalations, denial work, reconciliation, reports) with a measurement method. | |
| ☐ | Negotiate | Outcome measures such as days in AR are reviewed jointly against an agreed baseline. | |
| ☐ | **Must have** | Repeated misses follow a set path to a real remedy or a termination right. | |
| ☐ | **Must have** | The liability cap is proportionate, and counsel has read every guarantee next to it and any exclusive-remedy clause. | |
| ☐ | **Must have** | The vendor indemnifies you for its own billing errors, data breaches and excluded personnel. | |
| ☐ | Negotiate | The vendor carries professional liability and cyber insurance at stated limits, with certificates on request. | |
| ☐ | Negotiate | Facility obligations (census, admissions data, assessments, sign-offs) are written down with dates. | |

## 6 KPIS AND REPORTING

A KPI without a fixed formula can be redefined later.

| | PRIORITY | CONFIRM IN THE DRAFT | WHAT IT SAYS NOW, OR WHAT TO ASK FOR |
|---|---|---|---|
| ☐ | **Must have** | First-pass acceptance rate: initial claims accepted by the payer divided by initial claims submitted. | |
| ☐ | **Must have** | Initial denial rate: denied divided by adjudicated, in count and dollars, by reason. | |
| ☐ | **Must have** | Days in AR: ending AR divided by average daily net revenue, stating whether legacy AR is included. | |
| ☐ | **Must have** | AR over 90 days: aged AR divided by total AR on the same aging basis. | |
| ☐ | Negotiate | Cash posting lag and appeal win rate have written formulas. | |

| | PRIORITY | CONFIRM IN THE DRAFT | WHAT IT SAYS NOW, OR WHAT TO ASK FOR |
|---|---|---|---|
| ☐ | **Must have** | Medicaid pending aging and unbilled or held claims are reported with owner and next action. | |
| ☐ | **Must have** | KPIs are reported by facility and by payer, on a set business day. | |
| ☐ | Negotiate | Formulas can't change without written agreement, and your controller can see the claim-level records. | |

## 7 COMPLIANCE, SECURITY AND DATA

You stay responsible for claims submitted for your facility.

| | PRIORITY | CONFIRM IN THE DRAFT | WHAT IT SAYS NOW, OR WHAT TO ASK FOR |
|---|---|---|---|
| ☐ | **Must have** | The BAA has been checked against HHS's sample provisions and 45 CFR 164.504(e), and its data-return terms match the contract. | |
| ☐ | **Must have** | The vendor shares a current SOC 2 Type II or HITRUST report, or a recent third-party HIPAA risk assessment. | |
| ☐ | Negotiate | Staff and subcontractors are screened against exclusion lists monthly, as OIG recommends, with proof supplied to you. | |
| ☐ | **Must have** | Audit roles are named: who receives a request, who pulls billing and clinical records, who approves the response. | |
| ☐ | Negotiate | The vendor's clearinghouse is named, with an outage notice period in hours. | |
| ☐ | **Must have** | Subcontractors and every location where your data is accessed, including outside the U.S., are disclosed. | |
| ☐ | **Must have** | You own all claim, remittance, AR and resident account data, and can export it at any time. | |

## 8 CLAUSES MOST DRAFTS LEAVE OUT

Add these if they're missing.

| | PRIORITY | CONFIRM IN THE DRAFT | WHAT IT SAYS NOW, OR WHAT TO ASK FOR |
|---|---|---|---|
| ☐ | Negotiate | Key personnel: your account lead and backup are named, with written notice before either changes. | |

| | PRIORITY | CONFIRM IN THE DRAFT | WHAT IT SAYS NOW, OR WHAT TO ASK FOR |
|---|---|---|---|
| ☐ | Negotiate | Audit right: you can review claim-level work and bring in an outside reviewer once a year at no extra cost. | |
| ☐ | Negotiate | Rule changes: the vendor keeps systems and processes current with the October 1 SNF PPS update and state Medicaid changes at no extra charge. | |

## 9 TERM, TERMINATION, RUNOUT AND DATA RETURN

Negotiate the exit while you still have leverage.

| | PRIORITY | CONFIRM IN THE DRAFT | WHAT IT SAYS NOW, OR WHAT TO ASK FOR |
|---|---|---|---|
| ☐ | **Must have** | The term and any auto-renewal are clear, with a notice window short enough to act on. Put the date in your calendar at signing. | |
| ☐ | **Must have** | Termination for convenience and for cause, notice and cure periods, and any exit fee are clear. | |
| ☐ | **Must have** | The runout names which accounts it covers, its price, its reporting and its end point. | |
| ☐ | **Must have** | Claim histories, AR notes, remittances, denial files, Medicaid pending records and authorization logs come back by fixed dates and formats, even during a fee dispute. | |
| ☐ | **Must have** | Each open billing period has one submitter, and portal, clearinghouse and ERA access is confirmed before service ends. | |
| ☐ | Negotiate | Unapplied cash and credit balances are reconciled at exit. | |
| ☐ | Negotiate | The clause passes the stress test: a returned Medicare claim, a due MA appeal, a Medicaid approval and a payment without remittance all have an owner. | |

## Want a second read of your draft agreement?

Send LTCPro's long-term care billing team the agreement you've been given. We'll mark up the scope, service levels, fee definitions and exit terms from an operator's point of view. It's an operational review, not legal advice.

**Contact us at ltcpro.us**

### About LTCPro

LTCPro is a U.S.-based back-office outsourcing and revenue cycle management company built for long-term care. It supports skilled nursing and assisted living facilities in the United States with revenue cycle management, medical billing and accounts receivable, prior authorization, accounts payable, general ledger and bookkeeping, and payroll. LTCPro is headquartered in Somerset, New Jersey, and is part of SiriNiti Techsource Inc. (dba ProMantra).