



NEW HAVEN PUBLIC SCHOOLS

## Operations Memorandum

**To:** New Haven Board of Education Finance and Operations Committee  
**From:** Sue Peters-Director: School Health Centers/Dental Clinics  
**Date:** July 11, 2023  
**Re:** Agreement between BOE and Medical Billing of CT

**Answer all questions** and have a representative ready to present the details of each question during the Finance & Operations meeting or this proposal may not be advanced for consideration by the full Board of Education.

Company Information		
Vendor Name:	Medical Billing of CT	
Doing Business as: (DBA)	Medical Billing of CT	
Vendor Address:	35 Jem Woods Road, Oxford, CT 06478	
Vendor Contact Name:	Michelle Allen	
Vendor Contact Email:	michelle@medicalbillingofct.com	
Is the contractor a minority or women owned small business?	yes	
Agreement/Contract Information		
New or Renewal Agreement/Contract?	Renewal	
Effective Dates: (mm/dd/yy) <small>Multi-yr. require Board of Aldermen approval</small>	From    October 1, 2023	To    June 30, 2024
Total Amount: <small>If Multi-yr. include yr. to yr. breakdown</small>	<u>Total \$9,000.00</u> Depends on amount billed: \$2.99 per claim 8% gross amount of payments collected from claims or \$1,000 month if 8% is less than \$1,000/mth	
Funding Source Name: Acct. #:	2534-5408-56694-0000	
Contract #: <small>(Local or State)</small>		



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### Key Questions:

#### 1. What specific service will the contractor provide:

This local vendor submits and/or resubmits all dental service claims from our school dental providers (dentist and registered dental hygienists). They also find student HUSKY numbers for hundreds of eligible students in preparation for billing for school-wide screens. They provide follow up with the State for any denied claims and resubmit if needed.

#### 2. How was the contractor selected? *\*Attach appropriate supporting documents*

☒ Quotes

☐ Sealed Bid # \_\_\_\_\_

☐ Sole Source # \_\_\_\_\_

☐ RFP# \_\_\_\_\_

☐ State Contract # \_\_\_\_\_

☐ Exempt Professional

☐ Accountant

☐ Actuary

☐ Appraiser

☐ Architect

☐ Artist

☐ Dentist

☐ Engineer

☐ Expert Professional Consultant

☐ Land Surveyor

☐ Lawyer

☐ Physician/Medical Doctor

#### 3. If the vendor was selected through Solicitation (Bid/RFQ/RFP) process; answer the following:

##### a. Please explain how the ~~vendor was chosen~~? *\*Attach Vendor Proposal*

This vendor was selected through an RFP about 5 years ago after another vendor contract was not renewed due to inadequate performance.

##### b. Who were the members of the selection committee? *(Minimum 3 members required)*

Sue Peters, Will Clark, Tracey Oberg (RDH)



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**Key Questions: - Continued**

- 4. If this is a renewal with a current vendor, has the vendor has met all obligations under the existing agreement/contract?**

Yes

- 5. If this agreement/contract is a Renewal, has the cost increase? If yes, by how much?** \*Attach Renewal Letters

No-it is actually less expensive than our 1<sup>st</sup> year with them, as we paid a one-time fee of \$5000 to transfer all student records to another HPPA compliant dental billing software platform (Advanced MD). The cost has remained the same since then.

- 6. If this new agreement/contract, has cost for service increased from previous years? If yes, by how much?**

NA

- 7. Is this a service that existing staff could provide? Why or why not?**

No. There is only one administrator in my entire department. This work would require billing expertise specific to CT regulations/processes, time (at least 20 hours/week) and software/training.



# NEW HAVEN PUBLIC SCHOOLS

## Agreement/Contract Processing Checklist

*To ensure timely processing of the submitted Agreement/Contract it is imperative to collect and provide all of the required documentation noted below and provide with submission to board.*

**Forms/Documents are available in: Drive G:\F&O Agenda Minutes\Agreement Contract Checklist\2022-2023**

<b>1. Has this vendor performed service(s) in prior fiscal years?</b>	
If Yes,	Vendor # _____
If No or New,	Vendor must provide completed W9
<b>2. A quotes or proposal submitting regarding the agreement/contract.</b>	
If RFP	Attach Vendor Submitted- Do not have this-RFP was about 5 years ago
Other	Copy of State Contract, Quotes, etc.
<b>3. <u>Certificates of Liability Insurance (COI) are required for ALL agreements/contracts, read the following and select the applicable Rider.</u></b> <b>It is the submitters responsibility to request the COI from the vendor and attach with submission; the COI from the Vendor <u>must match rider specifications outlined.</u></b> <b>Failure to obtain or incorrect COIs will be returned for revision and will delay its processing.</b>	
Rider 300	Professional Services – Onsite Umbrella; w/ Auto; w/ Workers Compensation
Rider 305	Professional Services – Onsite Umbrella; No Auto; No Workers Compensation
Rider 310	Professional Services – Onsite Umbrella; w/ Auto; No Workers Compensation
Rider 315	Professional Services – Onsite Umbrella; w/ Youth under 21
Rider 320	Professional Services – Offsite; No Auto; No Workers Compensation
Rider 325	Professional Services – Offsite; No Auto; No Workers Compensation; w/ Youth under 21
Rider 330	Professional Services – Offsite Attorney; No Auto; No Workers Compensation
Rider 335	Professional Services – Onsite; Physician/Dentist; No Auto
Rider 340	Professional Services – Onsite Physician/Dentist w/ Youth under 21
Rider 345	Professional Services – Onsite Temp Nurses
Rider 350	Professional Services – Cyber – Onsite
Rider 355	Professional Services – Cyber – Offsite
<b>4. The City of New Haven requires the information requested in the <u>Disclosure Affidavit</u> before any City agency, department, or city official seeking agreement/contract shall obtain them, notarized.</b>	
Emailed Disclosures are acceptable.	



**CITY OF NEW HAVEN**

New Haven, Connecticut 06510

**DISCLOSURE &  
CERTIFICATION  
AFFIDAVIT****1. EVERY SECTION MUST BE COMPLETED**

<b>Contractor/Vendor Name:</b>	Medical Billing of CT			
<b>DBA (if applicable)</b>				
	If you are a DBA, please be advised you must file a Trade Name Certificate with the CONH City/Town Clerk			
<b>Physical principal place of business:</b>	<b>35 Jem Woods Road</b>	<b>Oxford</b>	<b>ct</b>	<b>06478</b>
	Address	City	State	Zip
<b>Mailing Address:</b> (complete only if different from principal place of business):				
	Address	City	State	Zip
<b>Telephone #:</b>	203 870-1796			
<b>Email Address:</b>	info@medicalbillingofct.com			
<b>Contact Person:</b>	Michelle Allen			

**For the purposes of this Disclosure and Certification Affidavit, the following definitions apply:**

- (a) "Person" means one (1) or more individuals, partnerships, corporations, associations, or joint ventures.
- (b) "Contract" means any agreement, purchase order, Memorandum of Understanding, or other formal commitment entered into by the city to expend funds in return for work, labor, services, supplies, equipment, materials or any combination of the foregoing, or any lease, lease by way of concession, concession agreement, permit, or per agreement whereby the city leases, grants or demises property belonging to the city, or otherwise grants a right of privilege to occupy or to use said property of the city.
- (c) "City" means any official agency, board, authority, department office, or other subdivision of the City of New Haven "CONH"
- (d) "Affiliate Entity" means any entity listed in sections 5 or 6 below or any entity under common management with the Contractor.
- (e) "DOB" means Date of Birth for individuals

<b>State of</b>	Connecticut	<b>County of</b>	New Haven
<b>I,</b>	<b>being first duly sworn, hereby deposes and says that:</b>		
	Type your name above		
<b>2.</b>	I am over the age of 18 and understand the obligations of making statements under oath; I understand that the City of New Haven is relying on my representations herein. (click 2a or 2b)		
<b>2a.</b>	<input checked="" type="checkbox"/>	I am the corporate secretary or majority owner (including sole proprietorship) of:	Medical Billing of CT
			Type company name above
<b>2b.</b>	<input type="checkbox"/>	Or I am an individual and my name is:	
			Type individual name above

<b>3.</b>	Please click the applicable representation(s) regarding taxes or, if none of the below are accurate, attach an explanation of the status of the relevant tax obligations to this Affidavit		
<b>3a.</b>	<input type="checkbox"/>	As required by Conn. Gen. Stat. §12-41, the Contractor (and each owner, partner, officer, authorized signatory, or Affiliate Entity of the Contractor) has filed a list of taxable personal property with the City of New Haven for the most recent grand list and all taxes are current.	
<b>3b.</b>	<input type="checkbox"/>	The Contractor (including any owner, partner, officer, or authorized signatory thereof) is not required to file a list of taxable personal property with the CONH for the most recent grand list and does not owe any back taxes to the CONH, either directly or through a lease or other agreement.	
<b>3c.</b>	<input type="checkbox"/>	The Contractor or an owner, partner, officer, representative, agent or Affiliate Entity of the Contractor either i) has a PILOT agreement with the City of New Haven or ii) owes back taxes and has executed an agreement with the CONH to pay said back taxes in installment payments. Such agreement is attached and incorporated herein by reference and the payments under said agreement are not in default.	
<b>3d.</b>	<input checked="" type="checkbox"/>	Other than as may be described in section 3a-c above, the Contractor (including any owner, partner, officer, other authorized signatory, or Affiliate Entity) does not have any outstanding monetary obligations to the City of New Haven.	

<b>4.</b>	Please click the applicable representation about the Contractor's business registration: 4a-c or 4d if a-c does not apply	
<b>4a.</b>	<input checked="checked" type="checkbox"/> Contractor is a Connecticut corporation, partnership, limited liability company or sole proprietorship.	Type State registration # above
<b>4b.</b>	<input type="checkbox"/> Contractor is a foreign corporation, partnership, limited liability company or sole proprietorship but is registered to do business in the State of Connecticut.	Type State registration # above
<b>4c.</b>	<input type="checkbox"/> Contractor is a foreign corporation, partnership, limited liability company or sole proprietorship and is <b>not</b> registered to do business in the State of Connecticut. The Contractor is registered in the State of:	Type State name above
<b>4d.</b>	<input type="checkbox"/> Contractor has confirmed with the Connecticut Secretary of the State that the services it will provide pursuant to the Contract do not constitute doing business in the State of Connecticut and no registration with the Connecticut Secretary of the State is required. Contractor does otherwise affirm they have and will maintain the following State of Connecticut registrations, certificates, or approvals relevant to the Agreement (attach if Applicable)	

<b>5.</b>	The following list is a list of the names of <u>all</u> persons affiliated with the business of the Contractor who are also affiliated with the City of New Haven. For purposes of this Affidavit, "affiliated with the business of the Contractor" includes any current or former employee (including officers) of the Contractor or any owner, board member or agent of the Contractor, or of any subsidiary or parent company of the Contractor, and "affiliated with the City of New Haven" means any employee, agent, public official, board member, commissioner or any other person serving in an official capacity for or on behalf of the City of New Haven. If none state none. Use additional sheet if necessary (must be on company letterhead and notarized):			
	<b>Name</b>	<b>City Affiliation Role &amp; Time Frame</b>	<b>Contractor Affiliation Role &amp; Time Frame</b>	<b>DOB</b>
<b>5a.</b>				
<b>5b.</b>				

<b>6.</b>	Contractor must disclose all existing and recent contracts with the City. The following list is a list of all contracts in which either the Contractor, any person affiliated with the business of the Contractor or an Affiliate Entity of the Contractor provides, or has provided, services or materials to the City within one (1) year prior to the date of this disclosure. If none, state none. Use additional sheet if necessary (must be on company letterhead and notarized)		
	<b>Name of Contractor or Affiliate</b>	<b>Affiliation (if applicable)</b>	<b>Contract Number</b>
<b>6a.</b>			
<b>6b.</b>			
<b>6c.</b>			
<b>6d.</b>			


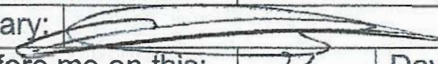
<b>7.</b>	The Contractor possesses an ownership interest in the following business organizations, if none, state none. Use additional sheet if necessary (must be on company letterhead and notarized):		
	<b>Organization Name</b>	<b>Address</b>	<b>Type of Ownership</b>
<b>7a.</b>			
<b>7b.</b>			

<b>8.</b>	The following persons and/or entities possess an ownership interest in the Contractor. If the Contractor is a corporation, list the names of each stockholder whose shares exceed twenty-five (25) percent of the outstanding stock. If none, state none. Use additional sheet if necessary (must be on company letterhead and notarized):			
	<b>Name</b>	<b>Title</b>	<b>% of Ownership</b>	<b>DOB</b>
<b>8a.</b>	Michael Allen	COO	49	4/26/78
<b>8b.</b>	Michelle Allen	CEO	51	7/18/70

<b>9.</b>	If the Contractor conducts business under a trade name, the following additional information is required: the place where such entity is incorporated or is registered to conduct such business; and the address of its principal place of business, if none, state none. Use additional sheet if necessary (must be on company letterhead and notarized):		
	<b>Trade Name</b>	<b>Place of Incorporation/Registry</b>	<b>Principal Place of Business</b>
<b>9a.</b>			
<b>9b.</b>			



I hereby certify that I am duly authorized to sign this Affidavit and that the person who will sign the Agreement (if required) with the City on behalf of the Contractor will be duly authorized to execute the same. I hereby further certify that the statements set forth above are true and complete on the date hereof and that I, or another authorized individual of the Contractor, will promptly inform the City, in writing, if any of the information provided herein changes or is otherwise no longer accurate at any point during the execution of the referenced Agreement. I understand that any incorrect information, omission of information or failure of the Contractor to update this information, as described in the foregoing sentence, may result in the immediate termination of all agreements the Contractor has with the City of New Haven and disqualification of the Contractor to further contract with the City.

<b>Signature of person completing this form:</b>			
<b>Title of person completing this form:</b>	CEO		
<b>Contractor/Vendor Name:</b>	Medical Billing of CT		
<b>Date:</b>	06/22/23		
	6/23/2023		
<b>THIS FORM MUST BE NOTARIZED</b>	<b>NOTARY SEAL (if available)</b>		
<b>Signature of Notary:</b>			
<b>Subscribed and sworn to, before me on this:</b>	23	Day of	June 20 23
<b>My Commission Expires:</b>			

**MARK J. LUCAS, JR.**  
**NOTARY PUBLIC**  
**State of Connecticut**  
**My Commission Expires**  
**May 31, 2028**



## MEDICAL BILLING OF CT

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### Service Agreement for New Haven Public Schools.

Date

June 2, 2023

Services Performed By:

MEDICAL BILLING OF CT  
35 Jem Woods Road  
Oxford, CT 06478

Services Performed For:

New Haven Public Schools  
54 Meadow Street, 3rd Floor  
New Haven, CT 06519

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This Agreement entered into on the 2nd day of June, 2023 effective, the 1st day of October, 2023, by and between the New Haven Board of Education (herein referred to as the Client) and, Medical Billing of CT located at 35 Jem Woods Road, Oxford, CT (herein referred to as MBCT).

WHEREAS, MBCT is a healthcare billing and service company which provides computerized claims, billing, and collection services to healthcare providers and which files medical insurance claims on behalf of healthcare providers with government, healthcare, commercial companies and other entities by electronic and paper means, and which also provides for billing services directly to patients or for patient's portion of healthcare provider fees not covered by insurance; and,

WHEREAS, the Client desires to retain MBCT to provide it with claims and billing services whereby MBCT will file insurance claims with government, healthcare, commercial companies and other entities by electronic and paper means on behalf of Client;

NOW, THEREFORE, in consideration of the promises and covenants contained herein and for other valuable consideration, the receipt and adequacy of which is hereby acknowledged, the parties agree as follows:

The intent of this document is to confirm the terms of engagement of Medical Billing of CT (MBCT) to assist NHPS with the discussed Medical, Behavioral and Dental Billing Service. This Agreement will



outline the basic responsibilities and objectives for MBCT's Medical Billers during the course of this engagement.

**SCOPE OF SERVICE:** *Brief description of service deliverables. In addition, please attach a detailed Scope of Service that describes all deliverables, locations and costs for service, including supplies, materials and travel, if applicable:*

## Scope of Work for Medical, Behavioral and Dental Billing

MBCT shall provide the Services and Deliverable(s) as follows in a timely manner:

- I. Process all the Client's Medical, Behavioral and Dental insurance claims for payment by government, healthcare, commercial companies and other entities by either electronic or paper means when necessary. MBCT will process and submit all Clients' claims within eight (8) days by electronic means wherever possible, and by paper means otherwise when no other method is supported for billing.
- II. MBCT will bill Dental claims from Denticon and/or by using excel sheets (for dental screenings and services) to bill Medicaid DSS, other insurance carriers to follow in the future.
- III. MBCT will be relying on the accuracy of the data entered by NHPS employees, Denticon and the accuracy of the excel sheets to properly bill claims to Medicaid DSS (example: demographic info, DOB and ID's numbers).
- IV. Post the payments received from the insurance payer or funding source to the patient file via Electronic Remittance into AdvancedMD Practice Management web based Software within 8 days of receiving ERA and 15 days of receiving paper EOB's.
- V. File any secondary or tertiary claims when necessary.
- VI. MBCT will obtain Medicaid numbers and check eligibility insurance benefits when proper demographics information is provided by client, when needed for students who receive medical behavioral or dental services within 8 business days of receipt of list.
- VII. Review all Explanation of Benefits (EOB) forms and respond to all billing inquiries from the payers and patients.
- VIII. Denticon Fees: MBCT will deduct the costs for Denticon bill submission fees from their monthly invoices.
- IX. **Reports:** Produce accurate and complete monthly provider productivity and credit balance reports and advise the Client of any refunds due to payers for services billed hereunder on a timely basis.
  - A complete Report the number of claims submitted, paid and denied (with associated dollar amounts) will be provided monthly BY PROVIDER, By School and BY SERVICE rendered within ten (10) business days following last day of every month
  - MBCT will provide client with **reason for denials** within ten (10) days of reported denial for any Dental, Medical and Behavioral **and provide guidance (within 10 days of reported denial)** to clinicians and SHC Director about how to fix and will resubmit claims on behalf of client

- MBCT will provide client (Sue Peters and Laura Benevento) with a reimbursement payment table by service within 5 business days following EACH DSS payment cycle (following DSS payment 2 week schedule)
- X. With the prior consent of the Client, timely issuing refunds of overpayments in the name of the Client to payers.
- XI. Maintain billing and collection records for Medical in AdvancedMD under Notes Section and update records.
- XII. MBCT shall promptly notify Client of any actual or suspected overpayment paid to or received by Client and shall assist Client in reviewing such actual or suspected overpayment so that Client may comply with their obligations under federal and state laws.
- XIII. **Support:** Primary Support and maintenance will be provided at no additional cost throughout the life of this agreement using AdvancedMD technical support and MBCT as backup support, with response provided within a four (4) hour time period Monday through Friday during regular business hours of 9:00AM – 5:00PM
  - MBCT will provide timely billing related support to NHPS providers, staff and supervisors and respond to inquiries or requests with staff within 2 business days in writing (copy Sue Peters on all communication with program staff).
  - MBCT will meet with NHPS staff at least quarterly and/or by request to review billing data and discuss issues, plans etc. to maximize billing revenue.
  - MBCT will provide ongoing assistance with obtaining HUSKY identification numbers for students using our communication protocol and spreadsheets prior to screens, and correct any identified names/numbers on the spreadsheets.
- XIV. NHPS owns all student and billing claim data. MBCT will transfer all data to NHPS per arrangement with NHPS IT and MBCT upon request of Client and/or within 15 business days of termination of contract between MBCT and NHPS.

## Client Responsibilities for Medical and Dental

- I. Client agrees to make available to MBCT all information necessary to properly process the Client's claims and to submit all such billing and insurance information to MBCT for proper billing. MBCT will solely rely on accurate information coming from clients AdvancedMD EHR software.
- II. Client acknowledges that MBCT will rely on proper name and DOB for claims submission.
- III. Client understands that MBCT will have no authority over client's AdvancedMD software.
- IV. Client will pay for all fees associated with Denticon software, and pass the usage fees to MBCT monthly to be deducted from MBCT invoices
- V. Client understands that MBCT will NOT provide insurance pre-authorizations.
- VI. Client warrants and represents that all such claims and billing information is entirely accurate and truthful to the best of their knowledge coming over from AdvancedMD EHR software & Denticon and or other third party software. If any investigation is initiated or if any action is

brought by any individual, company, or entity whatsoever regarding any of the claims filed by MBCT on behalf of Client, then Client agrees to cooperate fully in any such investigation or action and shall provide all relevant supporting documentation to support the claim(s) filed.

- VII. Client will need one-point person to work with MBCT for the data entry work to be entered into the AdvancedMD practice management software, such as new patient's demographics info, insurance cards, and daily charge out using a superbill format, online charge entry or iPad entry into the billing system. Other responsibilities include scheduling patients, collecting copay, and handling check-in and check-out procedures.

## Negotiated Client Rate for Billing Services

Client will pay MBCT 8% of the total (gross) amount collected with a minimum of one thousand dollars (\$1000.00) from all funding streams with which the Provider/ Client is credentialed within or out of network on a monthly basis. The Client agrees to provide copies of all Explanation of Benefits (EOB) forms received from insurance payers to MBCT as well as records of payments received directly from patients.

*(Example: MBCT bills out \$130 claim to Anthem, Anthem in returns pays \$95.00 for the claim, MBCT will bill 8% on the \$95.00 and invoice for \$7.60 for that claim).*

## Client Rate for AdvancedMD EHR\PM Software

<b>Summary of fees for NHPS and schedule of payments</b>	<b>Payment Due Date:</b>
\$2.99 per encounter for AdvancedMD EHR\PM	Due within 45 business days of invoice received
\$150 minimum per month for AdvancedMD EHR\PM to maintain software subscription, this also applies for any months not in use.	Due within 45 business days of invoice received
8% of gross amount of payments collected from claims	Due within 45 business days of invoice received
Any Additional EHR\PM Training \$150	Due within 45 business days of invoice received
A onetime cost of up to \$5000.00 conversion fee to extract Practice fusion EHR to AdvancedMD EHR	Due within 45 business days of invoice received



## AdvancedMD PM and EHR Software is included

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<ul style="list-style-type: none"><li>✓ Practice Management web based</li><li>✓ Scheduler View &amp; Control in One Pain of Glass</li><li>✓ Flexible &amp; customizable documentation Advanced Reporting with practice's financial health</li><li>✓ Practice on the go with iPad &amp; iPhone</li><li>✓ 99% uptime</li></ul>	<ul style="list-style-type: none"><li>✓ Advanced Billing /Capture Charges anytime anywhere</li><li>✓ Built in Clearing House/EDI</li><li>✓ Free automatic Software updates included.</li><li>✓ Backed up and secure with military-grade encryption</li><li>✓ Ongoing support with response within two-hours from time of request</li></ul>
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“*Billable Encounter*” means a unique visit number in the Hosted Programs or the Third Party Services for which charges are posted during the billing month, but excluding visit numbers (i) created by the system (with a charge code typically beginning with “#”) and (ii) for which all charges are voided during the billing month, and for which a claim has not been sent to a payer. Encounter overages are \$2.99 per encounter

MBCT will close its books for billing purposes on the last day of each month. Prior to monthly billing, a review will be held between Client and MBCT to ensure that all obligations related to the billing have occurred.

MBCT will bill the Client for its services on the fifth (5<sup>th</sup>) business day of each succeeding month for the previous month's processing. The Client will pay MBCT for its services within forty-five (45) days of receipt of MBCT's invoice. If the Client fails to submit payment within forty-five (45) days of receipt of an undisputed invoice, the Client will pay an additional three (3) percent per month late charge for each month or any portion thereof payment. If payment is not received within forty-five (45) days, MBCT will advise CLIENT in writing of its intent to stop all billing services to all insurance carriers within thirty (30) days until payment is received.

## Confidentiality

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All patient information and data provided by the Client to MBCT shall be kept confidential and shall not be disclosed to anyone outside of MBCT other than to the extent necessary for MBCT to process and submit claims for the Client. In addition, the Client will not divulge the contents, terms or conditions of this Service Agreement (SA) to any third party without the express written consent of MBCT.

Invoices shall be submitted monthly in arrears, referencing this Client's SA to the address indicated above. Each invoice will reflect charges for the time period being billed and cumulative figures for previous periods. Terms of payment for each invoice are due upon receipt by Client of a proper invoice.

MBCT agrees, and shall cause its employees, agents and contractors to agree, that the services they render hereunder shall be rendered in compliance with all applicable laws relating to the confidentiality and security of patient information, including and without limitation, the Health Insurance Portability and Accountability Act (HIPAA) of 1996, and any current and future regulations promulgated thereunder, as amended from time to time. MBCT shall not access, use or disclose protected health information (as that term is defined by HIPAA) except as set forth in that certain Business Associate Addendum entered into between the parties.

## Reporting within AdvancedMD

MBCT shall provide CLIENT management with reports regarding the practices A/R Health. There are more than 150 standard reports, and custom reports available for an additional charge. MBCT gives the Client details and visibility they need to effectively manage the business side of their medical practice.

See monthly reports request in first section

## Errors and Omissions

It is recognized by the Client that errors in processing claims may occur, resulting in the disallowance of claims and/or demands that the Client return funds paid to them by a payer. The disallowance of claims and/or demands for return of funds paid may be the result of human error, whether by the Client or MBCT, but may also be the product of existing ambiguities in the laws and regulations regarding the appropriate manner of processing claims and/or eligibility for reimbursement for various types of services.

MBCT will take commercially reasonable and appropriate measures, at its sole cost and expense, to promptly correct any error to the extent such error results from an act or omission of MBCT or its agents, employees or contractors.

The Client will indemnify, defend, and hold MBCT harmless for any and all disallowance of claims, and any and all demands, claims, suits, actions or judgments for return of funds arising out of the provision of incorrect or incomplete information provided by Client to MBCT.

MBCT agrees to indemnify, defend, and hold harmless Client and its officers, governing body, employees, agents, and contractors from any and all loss, liability, damage, cost, and expense, including and without limitation civil monetary penalties, monetary settlements, fines, damages as a result of attorney general enforcement, and attorneys' fees resulting or arising from: (i) the return of reimbursements to payers due to an error or mistake by MBCT or any of its agents, employees or contractors; (ii) violation of any applicable law by MBCT or any of its agents, employees or contractors, including but not limited to HIPAA, state data privacy laws and Medicaid reimbursement laws, regulations, rules, bulletins and

guidelines; or (iii) the use or disclosure of any reimbursement information provided to MBCT by Client not consistent with applicable law or regulation or this Agreement.

It is further agreed by the parties that in the event that the Client is required to return funds due to inaccurate information provided by Client to MBCT, any portion of those amounts that were paid to MBCT as compensation for MBCT's provision of services under this Agreement will be non-refundable.

## Representations and Warranties

MBCT acknowledges that Client is relying on these representations and warranties as essential elements to this agreement, representing as they do, material inducements, without which Client would not have entered into this Agreement.

(a) General Services Warranty. MBCT warrants that all services provided shall conform to the level of quality performed by experts regularly rendering this type of service.

(b) Qualifications. MBCT warrants all employees, agents, and subcontractors engaged to provide items or services under this agreement (collectively "Personnel") possess and will maintain all the skills, experience, and qualifications necessary to provide the services contemplated by this agreement, including any required training or certification.

(c) Good Standing. MBCT warrants that MBCT is a legally organized entity in good standing under the laws of the state of its organization and, where required, in good standing under the laws of the State of Connecticut.

- (d) Non-infringement. MBCT warrants that the MBCT's services and/or Client's use of products, processes, techniques and methodologies provided by MBCT or developed by MBCT shall not infringe upon the copyright, patent, or other proprietary rights of others.

(e) Not Excluded. MBCT warrants that neither MBCT, nor, to the best of MBCT's knowledge, Client, is excluded from participating in the Medicare or Medicaid program nor currently debarred or suspended or listed on the General Services Administration's ("GSA") List of Parties Excluded from Federal Procurement or Non-Procurement Programs in accordance with Executive Orders 12549 and 12689, "Department and Suspension". MBCT shall immediately notify Client if it becomes debarred or suspended during the term of this agreement. MBCT further represents that no adverse action by the federal government that will or may result in exclusions from a federal health care program has occurred or is pending or threatened against MBCT or its affiliates, or to the best of its knowledge, against any Personnel. MBCT agrees that it shall not perform any act that shall cause MBCT to be



excluded from a federal health care program or debarred, suspended or listed in the GSA's List of Parties Excluded from Federal Procurement or Non-Procurement Programs during the term of this Agreement.

(f) Compliance with the Laws. MBCT and its Personnel shall perform its/their duties, obligations, and responsibilities under this agreement in compliance with all applicable laws, regulations and regulatory guidelines, including and without limitation, Medicare and Medicaid rules and regulations.

## MISCELLANEOUS TERMS

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- During the term of this Service Agreement, the Client will not use the services of any other claims processing companies and will allow MBCT to process all of the Client's medical insurance claims from all funding streams at all of its locations for a one (1) year commitment.
- MBCT will be serving as a conduit of information and claims data between Client and many insurance payers, both government and commercial. Client will be providing all such claims information and data to MBCT, including but not limited to procedure codes, identifying the exact procedures Client has performed on patients. Client verifies that all such procedures were in fact performed on the patients as specified. MBCT has no authority to and will not change any of these procedure codes without the express permission and direction of Client.
- This Service Agreement shall be interpreted under the laws of the State of Connecticut and any disputes between the parties concerning the validity, interpretation or performance of any of the terms or provisions of this Service Agreement or of any rights or obligations of the parties hereto shall be resolved in Connecticut. If MBCT discovers evidence of misconduct by CLIENT relating to billing, MBCT may refrain from submitting questionable claims and notify CLIENT of its determination in writing. If MBCT discovers credible evidence of CLIENT's continued misconduct following such a notice or discovers willful, deceptive, flagrant, fraudulent or abusive conduct by CLIENT, MBCT may (i) refrain from submitting any claims MBCT determines to be false or inappropriate, (ii) terminate this Agreement, without penalty, immediately on written notice, and/or (iii) report the misconduct to appropriate State and/or Federal authorities.
- This Service Agreement and any attached Appendix represent the entire agreement between the parties and shall not be modified unless done so in writing signed by or on behalf of both parties.
- Access to Records. If Section 952 of the Medicare and Medicaid Amendments of 1980, 42 U.S.C. § 1395x(v)(1)(I), is applicable to this agreement, then MBCT shall make available upon written request by the Secretary, U.S. Department of Health and Human Services (the "Secretary") or upon request by the Comptroller General, or any of their duly authorized representatives, this agreement and all books, documents and records of the MBCT that are necessary to certify the nature and extent of the costs incurred by the Client with respect to the services furnished under this agreement.

- **Audits.** MBCT agrees that in the event that the Client is audited by federal or state authorities or a third party payer with respect to compliance with Medicare or Medicaid reimbursement, billing and/or collection laws or practices, or regulations and policies applicable to billing and collection services provided during the term of this agreement, or any claim of overbilling or other impropriety is asserted with respect thereto, MBCT shall provide such services, information and documentation as the Client may reasonably request in connection with such audit or claim (and any appeal therefrom).
- **Obligation after Termination.** Except as otherwise provided herein or in any amendment hereto, following the effective date of termination of this agreement, both parties shall cooperate in the final reconciliation of fees owed hereunder, which shall be calculated by MBCT no less than six (6) months after termination of this agreement. In addition, upon termination of this agreement, and upon request by the Client, MBCT shall turn over to the Client on electronic media or in such other format as Client shall request, all of Client's data, records and information in MBCT's possession.
- **APPROVAL:** This Agreement must be approved by the New Haven Board of Education prior to service start date. Contractors may begin service no sooner than the day after Board of Education approval.
- **TERMINATION:** The Board may cancel this agreement for any reason upon thirty (30) days' written notice sent to MBCT by certified U.S. mail, return receipt requested; provided however, that the Board shall be responsible to MBCT for all services rendered by MBCT through the last day of thirty (30) day notice period, as long as the Agreement was approved by the Board prior to the start date of service.
- **Fiscal support** for this Agreement shall be by Medicaid Account- SHC Program of the New Haven Board of Education, **Account Number:** 2534 - 5408 – 56694.
- This agreement shall remain in effect from October 1st, 2023, to June 30th, 2024.

**HOLD HARMLESS:** MBCT shall insure and/or indemnify the Board and its members, employees and agents against all claims, suits, and expenses, including reasonable attorney's fees, in connection with loss of life, bodily injury or property damage arising from any neglect act or omission of MBCT or its employees or agents. Further, MBCT covenants and agrees that it shall hold the Board and its members, employees and agents harmless against any and all claims, suits, judgments of any description whatsoever caused by MBCT's breach of this agreement or based upon the conduct of MBCT, or its agents or its employees or arising out of in connection with their activities under this agreement.

IN WITNESS WHEREOF, the parties have executed two (2) counterparts of this Agreement as of the 2<sup>nd</sup> day of June 2023 but effective October 1st, 2023.

**MEDICAL BILLING OF CT**



Contractor Signature

6-23-23

Date

Michelle Allen CEO

Contractor Name Printed or Typed

**NEW HAVEN BOARD OF EDUCATION**

Yesenia Rivera, President

Date





# CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY)

06/17/2023

THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AFFIRMATIVELY OR NEGATIVELY AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW. THIS CERTIFICATE OF INSURANCE DOES NOT CONSTITUTE A CONTRACT BETWEEN THE ISSUING INSURER(S), AUTHORIZED REPRESENTATIVE OR PRODUCER, AND THE CERTIFICATE HOLDER.

**IMPORTANT:** If the certificate holder is an ADDITIONAL INSURED, the policy(ies) must have ADDITIONAL INSURED provisions or be endorsed. If SUBROGATION IS WAIVED, subject to the terms and conditions of the policy, certain policies may require an endorsement. A statement on this certificate does not confer rights to the certificate holder in lieu of such endorsement(s).

<b>PRODUCER</b> Hiscox Inc. 520 Madison Avenue 32nd Floor New York, NY 10022	<b>CONTACT NAME:</b> <b>PHONE (A/C, No, Ext):</b> (888) 202-3007 <b>E-MAIL ADDRESS:</b> contact@hiscox.com <b>FAX (A/C, No):</b>
<b>INSURED</b> Medical Billing of CT LLC 350 CENTERROCK GREEN 9 Oxford CT 06478	<b>INSURER(S) AFFORDING COVERAGE</b> <b>INSURER A:</b> Hiscox Insurance Company Inc <b>INSURER B:</b> <b>INSURER C:</b> <b>INSURER D:</b> <b>INSURER E:</b> <b>INSURER F:</b>
	<b>NAIC #</b> 10200

**COVERAGES****CERTIFICATE NUMBER:****REVISION NUMBER:**

THIS IS TO CERTIFY THAT THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

INSR LTR	TYPE OF INSURANCE	ADDL INSD	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS
	<b>COMMERCIAL GENERAL LIABILITY</b> <input type="checkbox"/> CLAIMS-MADE <input type="checkbox"/> OCCUR  GEN'L AGGREGATE LIMIT APPLIES PER: <input type="checkbox"/> POLICY <input type="checkbox"/> PROJECT <input type="checkbox"/> LOC OTHER:						EACH OCCURRENCE \$ DAMAGE TO RENTED PREMISES (Ea occurrence) \$ MED EXP (Any one person) \$ PERSONAL & ADV INJURY \$ GENERAL AGGREGATE \$ PRODUCTS - COMP/OP AGG \$ \$
	<b>AUTOMOBILE LIABILITY</b> <input type="checkbox"/> ANY AUTO <input type="checkbox"/> OWNED AUTOS ONLY <input type="checkbox"/> SCHEDULED AUTOS <input type="checkbox"/> HIRED AUTOS ONLY <input type="checkbox"/> NON-OWNED AUTOS ONLY						COMBINED SINGLE LIMIT (Ea accident) \$ BODILY INJURY (Per person) \$ BODILY INJURY (Per accident) \$ PROPERTY DAMAGE (Per accident) \$ \$
	<b>UMBRELLA LIAB</b> <input type="checkbox"/> OCCUR <b>EXCESS LIAB</b> <input type="checkbox"/> CLAIMS-MADE DED RETENTION \$						EACH OCCURRENCE \$ AGGREGATE \$ \$
	<b>WORKERS COMPENSATION AND EMPLOYERS' LIABILITY</b> ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH) If yes, describe under DESCRIPTION OF OPERATIONS below	<input type="checkbox"/> Y <input type="checkbox"/> N	N/A				PER STATUTE <input type="checkbox"/> OTH-ER <input type="checkbox"/> E.L. EACH ACCIDENT \$ E.L. DISEASE - EA EMPLOYEE \$ E.L. DISEASE - POLICY LIMIT \$
A	Professional Liability			UDC-4410103-EO-20	02/17/2024	02/17/2024	Each Claim: \$ 1,000,000 Aggregate: \$ 1,000,000

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (ACORD 101, Additional Remarks Schedule, may be attached if more space is required)

**CERTIFICATE HOLDER****CANCELLATION**

SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS.

AUTHORIZED REPRESENTATIVE

## A Guide To Your Professional Liability Policy

The following is a guide to your Professional Liability policy. We have identified several key coverage items along with the limits and deductibles you have selected. To make it easier, we have also added a brief explanation of those items.

We want you to feel confident about your new policy. If any of the information below is incorrect or if you have any questions, please contact one of our advisors at 888-202-3007 (Mon-Fri, 7am-10pm EST) or manage your policy at: [www.hiscox.com/manage-your-policy](http://www.hiscox.com/manage-your-policy).

### Your business details

<b>Name:</b>	Michael Allen
<b>Business name:</b>	Medical Billing of CT LLC
<b>Address:</b>	35 Jem Woods Road
<b>City:</b>	Oxford
<b>State:</b>	CT
<b>Zip code:</b>	06478
<b>Occupation:</b>	Medical Billing
<b>Telephone number:</b>	203-856-3936
<b>Email address:</b>	info@medicalbillingofct.com

### Your Professional Liability Policy

<b>Policy number:</b>	UDC-4410103-EO-20
<b>Policy effective dates:</b> This determines the time period during which your coverage applies.	From: February 17, 2020 To: February 17, 2024
<b>Total cost of policy:</b>	\$ 568.00

### Your limits explained

<b>Each claim limit</b> The total amount we will pay for damages, claim expenses (e.g. defense costs), and supplemental payments for each claim.	\$ 1,000,000
<b>Aggregate limit</b> The total amount we will pay for damages, claim expenses (e.g. defense costs), and supplemental payments during the policy period.	\$ 1,000,000
<b>Supplemental payments</b> The total amount we will pay for expenses your business reasonably incurs as a result of attending an arbitration proceeding or trial in the defense of a covered claim.	Maximum of \$250.00 per day, \$5,000 in total for your policy

**Deductible**

The amount your business must pay (per claim) before we will make any payment under the policy. This does not apply to supplemental payments.

\$ 500

**Retroactive Date**

This establishes how far back we will cover services you have performed (even if that date is before you were insured with Hiscox) for any unknown claims that may be made against you during the policy period.

January 1, 2010

**Other policy information****14 Day full refund**

Be confident that you have made the right choice. We give you 14 days to review your policy. If you are not satisfied and have not had any claims or losses, you can cancel your policy back to its start date and receive a full refund.

**Notice of claim**

If you have a claim, please call us at 866-424-8508. You may also e-mail us at [reportaclaim@hiscox.com](mailto:reportaclaim@hiscox.com)

**What does my Professional Liability Policy cover?**

For a summary showing examples of what you are and are not covered for, please read the Coverage Summary document.

This guide does not modify the terms and conditions of your policy, which are contained in your policy documents, nor does it imply any claim is covered or not covered. We recommend that you read your policy documents to learn the details of your coverage.