Single Case Agreements for Physicians and Surgeons

BLOG ARTICLES

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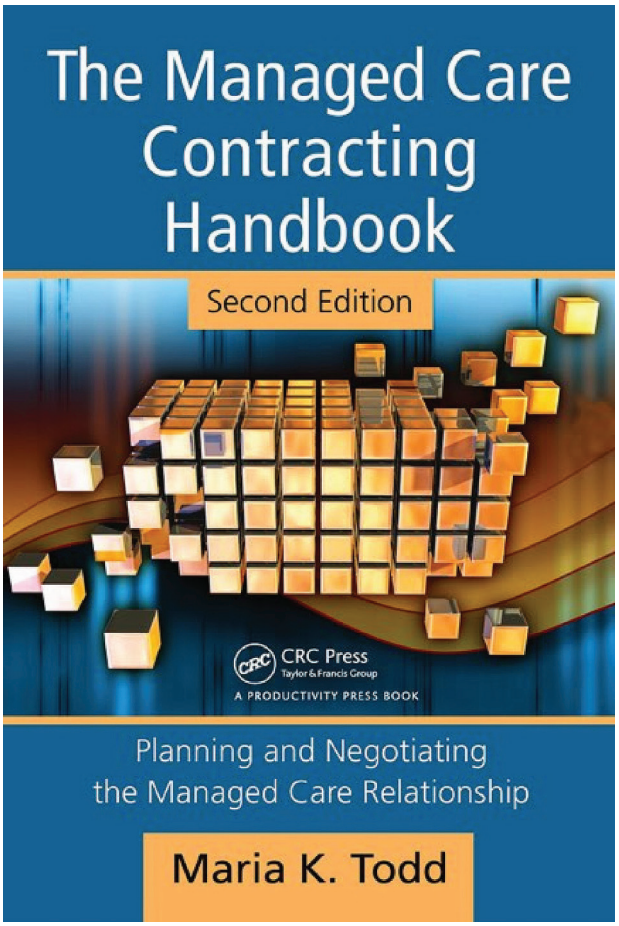

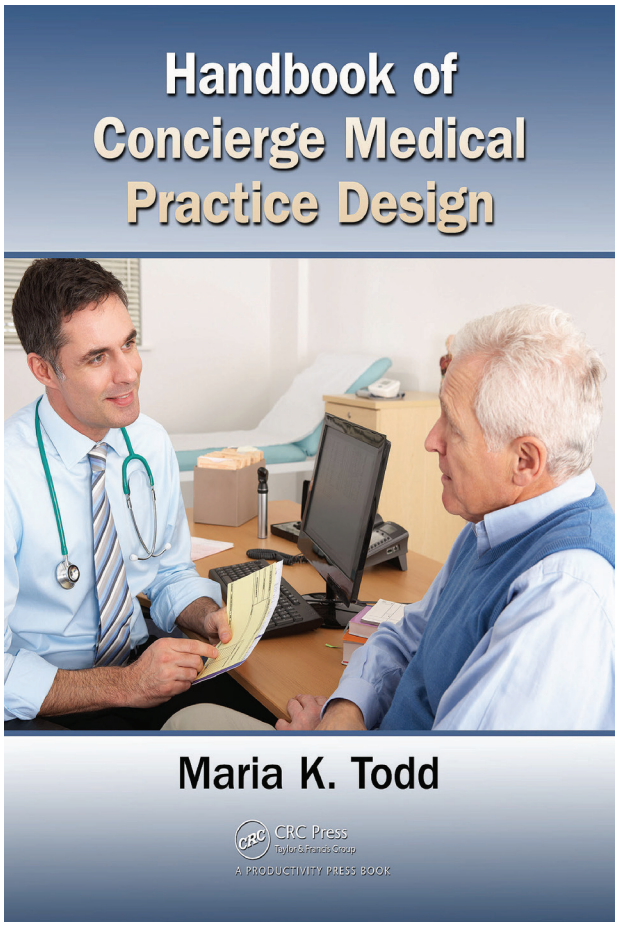

When you need a helpful resource to improve operations, strategy, contracting or other business matters, these two books may help you.

Order them from the publisher or through your favorite retail or online bookseller.

A Triple Win for You, Your Patient and Your Patient's Health Plan

As a specialist in a private concierge medical practice, you've chosen to terminate all insurance panel agreements. Patients will pay you directly for services (out-of-pocket). You provide patients with an invoice marked with dates of service, service codes, diagnosis codes and all payments paid by the patient.

Patients agree that if they have insurance, they acknowledge responsibility to submit the supplied invoice and to be reimbursed by their health benefit plan for out-of-network benefits, if any. Generally, these plans have a high deductible to be met before any out-of-network benefits take effect.

Comes now, a special case where you are willing to manage an exception to your policy. The problem is you aren't sure how to go about negotiating and executing a Single Case Agreement (SCA), for a special procedure, a surgery, or an episode of care involving services over a distinct period of time for a covered condition. The SCA will benefit all parties involved.

In this article, I've shared the essentials about SCAs so you can advocate on behalf of your patients when necessary, on your terms and conditions, and not have to capitulate to the very terms and conditions of standard managed care panel participant agreements that you previously decided to terminate.

Definition of a Single Case Agreement (SCA)?

A Single Case Agreement (SCA) is a contract between an insurance company and an out-of-network provider for a specific patient. It enables the patient to receive care and treatments or surgery from a provider using their in-network benefit schedule. This means that the patient will only have to pay their routine in-network co-pays for office visits from you, or surgery or a set of sequential treatments bundled into an episode of care after meeting their in-network deductible.

The Fee Negotiation

The fee you charge has been agreed to by the insurance company in advance will be for this unique episode of care, for this patient and no other for a specific date of service or date range and then it's over. I'll cover more on fees below.

How to Estimate the Value Proposition You Offer the Health Plan

SCAs are intended to address the specific needs of the patient. The insurance company or health plan will expect a cost benefit to negotiating a Single Case Agreement.

That cost benefit may be as simple as not having to negotiate a contract with a new provider if the network is inadequate to meet the risks of claims costs. In general, having been a manager of provider network contracting, I can assert that for many health plans, the activity-based costs and other expenses to negotiate, load-in and test the system to vet credentials, privileges, and recognize and pay a new provider can easily

total $8-$10,000. The SCA offers an elegant solution that is faster and less expensive than a full service contract on an ongoing basis.

Necessary Market Insight

Do your market research to pre-determine the likelihood that the health plan will agree to execute the SCA:

Scarcity:

- **Specialization**: You work in a clinical specialty that is not available with any of the in-network providers. Don't sell yourself short: your specialty could be as simple as cultural competency and language fluency.
- **Geography**: There are few in-network providers, none of which are located within a radius of a certain number of miles. Some states are very specific about this and set standards for public transportation accessibility, paved roads vs farm roads, or providers in a specific county in a ratio to enrollees in the plan.
- **Services** you provide will keep the patient out of the hospital, or will reduce the cost of the procedure to the health plan (e.g., medical travel surgeries) or reduce the cost of medications

Sequencing:

If the patient has been unable to secure an appointment with an in-network provider because of scarcity, and the plan would be required to self-report to regulators that they are out of compliance with regard to network adequacy, you help the patient appeal to the plan for an SCA with the out-of-network provider BEFORE commencing treatment. You'll lose tremendous leverage if you do this after the fact.

Continuity of Care:

- The patient may have **recently changed insurance providers**. Many states have enacted patient protection acts that require a health plan to agree to a limited number of visits within a specific time period (e.g., 60 days since insurance change), to allow the patient to continue treatment with the current out-of-network provider, while transitioning to an in-network provider. The SCA would be with the new health plan since the old health plan is no longer receiving premiums to pay you.
- For **psychotherapy and psychiatric providers,** if there is evidence that the individual might be a danger to him/herself or others, or if it would adversely affect the patient psychologically/mentally (such as setbacks in the progress made in therapy), if required to transition to an in-network provider, than a case could be made for extended continued care with the current provider.
- In the case of **maternity care,** many states have patient protection acts on the books that allow for much longer than 60 days.

Understanding your leverage in fee negotiations

Insurance companies and employer-sponsored health benefit plans may be legally obligated to provide patients with adequate treatment by properly trained professionals without out-of-network penalties if the network lacks adequate providers for a covered service. Therefore, if the insurance plan does not cover any out-of-network services, AND there are no in-network providers with your specialty or with your cultural competency or language fluency, you may be able to negotiate 100% of your usual and customary fee. The argument is that the patient is not simply choosing to see you, but has no other choice due to network inadequacy.

In the case of a current patient in need of continuation care, the rate negotiated may be based on the patient's informed consent and agreement to pay your usual and customary fees on the initial visit. Any discount or hardship courtesy extended to the patient must also be extended to the payer. You are not

permitted to charge the patient a lower out-of-pocket sliding scale rate or discounted rate, and charge the payer at 100% of your usual and customary fees. You may be able to back date the agreement by simply widening the date range for sequential care or a particular treatment or service but remember, your leverage decreases if you negotiate the SCA after the fact.

If the insurance company states that their policy is to "pay at highest in-network rate", you may be unsuccessful to negotiate 100% of your usual and customary rate. In that case, you have the option to decline to accept the SCA. This is another defense in the argument for addressing the SCA in advance, rather than after the fact. Because after the fact, you'll be required to present the 30-day patient termination letter if your patient decides that they cannot pay and cannot or will not apply for and qualify for a medical expense loan program, and the insurance company won't pay. Many of the medical expense loan programs will keep 30-40% of your fee if the patient goes that route, so take the reductions and cost of credit into account when setting the fee.

The SCA will also spell out any CPT codes authorized under the agreement, the start and end dates for treatment, and the number of visits or treatments. At the point where there are only a few visits remaining and you determine that your patient is not quite ready to be discharged from your service, you may request

for an amendment to extend or modify the SCA.

How long is the process, on average?

Generally, SCAs can take 3-4 weeks when initiated by the patient or provider. When initiated by a case manager hired by the health plan or a cost containment firm, the negotiation can be completed in a matter of 2-3 days.

About 15 years ago, I was hired by several providers across the nation to help with managed care and revenue management problems for hospitals and clinics Each day, they would receive calls from case managers who were not health plan employees on out-of-network cases. They would call after the case had been performed and the patient discharged. They would explain that they wanted to negotiate a discount rather than pay the full billed charges and send a fax to the person who answered the phone.

- One problem that arose was that was many negotiated without full authority to bind the payer, legally. So the first step was to require that they obtain signature on the SCA by a duly authorized officer of the payer.
- A second issue arose that they were "selling the intel" to others because there was no non-disclosure restriction in the document.
- A third issue arose when they applied the "single" case agreement to other plan participants without first obtaining agreement from the provider. That's a different agreement arrangement called a Continuous Discount Arrangement.
- A fourth issue arose for my clients doing medical tourism as they were bundling a fully-inclusive case rate and had no document to memorialize the understandings of the special carved out pricing.
- More recently, I've been hired to assist concierge physicians in both primary care and specialty care settings who were hit by the new "Provider Manual" updates published by Cigna, United and Aetna and the Blues, all of which now prohibit hybrid practices whereby the physician collects the membership fee for their amenities based services and accepts insurance for all fee-for service covered items paid by insurance for services with a CPT code.

The Model SCA I have supplied as a template on the next page will get you started. Best if you run it past your attorney to better hedge on enforceability. In the agreement I just hit on the essentials. They may prefer more detail. I like to keep things "non-nuclear", simple and unambiguous.

MODEL SCA

SINGLE CASE AGREEMENT

Identification of the Parties

This agreement is made by and between [INSERT provider name] (hereinafter referred to as "Provider") and [INSERT Payer name] (hereinafter referred to as "Payer").

Effective Date

The effective date of this agreement shall be _____, and the initial term shall expire on _____. (thirty days)

Recitals

WHEREAS, the parties have no previous Agreement in effect for which any discount is applicable; and

WHEREAS, the provider has agreed to accept the payment from health plan for an amount not to exceed 100% of the providers usual and customary billed charges in exchange for certain consideration; and

WHEREAS, the negotiator for the Payer has the authority to bind the Payer into this Agreement and cause them to honor the terms and conditions contained herein; and

WHEREAS the patient or other responsible party shall also benefit from this one-time adjustment with a commensurate discount of their applicable coinsurance, copayment, or deductible,

NOW THEREFORE in consideration of the mutual covenants contained herein, the receipt and sufficiency of which is hereby acknowledged, the parties agree:

Definitions

"Payer" shall mean any third party Payer, insurance company, self-funded employer, multiple employer trust, union trust, that has entered in an agreement with Health Plan to provide, arrange for, manage Covered Services to Members and to be financially responsible for the compensation of participating Providers for Covered Services.

Agreement

By your signature below you are binding PAYER NAME to reimburse PROVIDER for the healthcare services rendered according to the following terms.

1. If PAYER NAME remits and Provider receives reimbursement for services rendered within FIFTEEN (15) CALENDAR DAYS from the date of mailing the claim, PAYER NAME is entitled to a ----% discount off of total billed charges. **Include this provision only if you intend to extend a discount for accelerated payment. Otherwise remove it and replace with your language for 100% of usual and customary charges or whatever you negotiate with them.**

2. If PAYER NAME remits and Provider receives reimbursement for services rendered within THIRTY (30) CALENDAR DAYS from the date of mailing the claim, PAYER NAME is entitled to a ---% discount off of total billed charges. **ibid.**

3. Time is of the essence. If PAYER NAME does not pay Provider within thirty (30) calendar days of the mailing of the claim, the discount shall be canceled for all parties. In the event PAYER does not meet these criteria, no discounts will apply, and the Hospital shall be paid at 100% of billed charges, less any applicable coinsurance and/or deductible amounts. **ibid.**

4. The patient's UB-04/CMS-1500/invoice will show the actual billed charges and any payments paid by the patient.

5. It will be PAYER NAME responsibility to adjust the payment to reflect the applicable discount based on the terms specified above.

6. All payments are final. Any claim for refund for any reason shall be the responsibility of the insured individual.

7. Medical records, if requested, shall be supplied upon receipt of a properly executed request for medical records if accompanied by payment in the amount specified in _____ law or administrative code.

8. In no event shall PAYER offset payments against, or deduct overpayments from, any other payments it owes to PROVIDER.

9. PAYER shall provide written documentation and detailed reason, to both Provider and Participant, of any utilization management determination that services are not Medically Necessary. PROVIDER may seek payment from a Covered Person for services determined to be not Medically Necessary pursuant to the Utilization Management Program pursuant to this Agreement if PROVIDER obtains written consent to such payment for Covered Person prior to rendering services. For the purposes of this Section _____, PROVIDER's Conditions of Admission shall serve as Covered Persons written consent to such payment.

Confidentiality

Other than as required by law or a Governmental Authority, Hospital and [Payer or Affiliate(s) or Brokers] shall not disclose any provision of, nor allow any Person (other than Self-Funded Payers, Brokers, Provider's personnel, or [Payer] personnel or other listed individuals and entities) to see, read, use, copy or otherwise have access to this Agreement. Notwithstanding the foregoing, Hospital shall be permitted to submit any Explanation of Benefits (EOB) or other such payment advice or voucher to another secondary source of payment solely for the purpose of coordination of benefits. Any other use shall be construed as a material breach of this provision.

Assignment

Neither party may assign, delegate or transfer this Agreement or the rights granted herein without written consent of the other party, which consent shall not be unreasonably withheld.

Payer or its representative has read and understands this Agreement, and acknowledges that it shall be effective and binding upon the Payer and their respective successors and assigns. If this is executed by a representative of the Payer, the representative asserts that is has the power and authority to bind the company of which such representation is made.

This Agreement shall be effective as of the latest date signed by the parties below.

/ss/

CLIENT BRIEF *Ask*MariaTodd™

Do you have a short project you'd like to run past Maria Todd to request a little help? Please complete this brief questionnaire and send it to Maria@mercuryadvisorygroup.com or call +1 (800) 727.4160.

NAME:

TITLE:

ORGANIZATION:

LOCATION:

EMAIL:

TELEPHONE:

I want to discuss:

- ☐ Concierge Medicine Business Model Transition
- ☐ Practice Analysis / Market Analysis
- ☐ Managed Care Contract Termination
- ☐ Medicare Participation Termination
- ☐ Concierge Membership Package Creation
- ☐ Concierge Medicine Membership Contract
- ☐ Concierge Medicine Telehealth Services
- ☐ Concierge Medicine Marketing & Promotion
- ☐ Notifying Existing Patients of My Decision
- ☐ Social Media Marketing
- ☐ Concierge Medicine Rebranding
- ☐ Concierge Medicine Website Design / Re-design
- ☐ Patient Centered Medical Home Accreditation
- ☐ Adding new services not paid by insurers (HRT, PRP, Stem cells, Cosmetic, Wellness, Infusion, Chelation, etc.)
- ☐ Concierge hybrid model (Insurance + membership)
- ☐ Concierge all cash; no insurance
- ☐ Direct Pay (monthly-fee unlimited service model)
- ☐ Executive health / corporate programs
- ☐ Other: _____

I am:

- ☐ Ready to engage your assistance
- ☐ Shopping for a consultant

This project is:

- ☐ One-time only
- ☐ Ongoing
- ☐ Intermittent, as needed

I prefer to work with you

- ☐ in-person at your location
- ☐ In-person at my location
- ☐ Remotely as much as possible

Proposed start date: _____

PLEASE NOTE:

Recent industry changes with national managed care plans have eliminated hybrid concierge options. These changes apply no matter what Tax ID you will use for billing unless you are in a position to negotiate an exception by contract.

My policy: I offer a complimentary 15-minute introductory discussion to discover how I may be able to help you. Afterward, for advice and quick consults, I charge for my time in 15-minute increments. If travel is required, I charge actual expenses and bill daily flat rate.

About the Author

Maria Todd specializes in managed care and contracted reimbursement analysis and improvement initiatives and other business development projects in healthcare.

She leverages clinical, administrative, health law paralegal and health plan work experience to the benefits of her clients.

With decades of hands-on experience on strategic planning, go-to-market strategy, bundled pricing initiatives, and negotiating direct-with employer relationships, she works with hospitals, ASCs and medical groups on operational, revenue cycle, marketing and innovation projects. She's worked hands on as a practice and ASC administrator, hospital business office manager and as an OR nurse.

She helps clients build and improve pricing models and to negotiate fair, equitable shared-risk arrangements and bundled payment contracts with health plans and employers.

As the former CEO of Mercury Healthcare International, she recently downsized her firm to work independently as consultant to healthcare organizations. She's fearless, but seasoned when asked to implement new ideas and concepts. She declines more than half the projects to which she's invited due to time constraints and heavy existing client demands. That being said, she always makes time for a quick call or a brief consultation.

Maria is the author of 20 internationally-published books on healthcare business administration covering managed care and physician employment contracting, physician-hospital-health plan integration, business development, and healthcare marketing. She's published thousands of blog articles and is frequently interviewed for industry journals, magazine & news media.

She holds 1 registered trademark, 22 copyrights, and a U.S. patent pending. She has presented 2900+ speaking engagements in 117 countries on a variety of healthcare business topics to improve revenues, quality and curtail risks. She loves teaching and shares insights, tools, tips and tactics with workshop participants.

Maria's favorite assignments focus on managed care, health travel, clinical integration, social media marketing, branding, market research and healthcare industry software design.

She resides in St George, Utah with her husband and cats.

She is available to consult to healthcare organizations, self-funded employers, regulators, the media, the investor community, insurers, and pharma and medical device manufacturers.
Contact her at (800) 727.4160.